97TH CONGRESS
1st Session

SENATE

REPORT
No. 97-62

PART 1
DEVELOPMENTS IN AGING: 1980

A REPORT

OF THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

PURSUANT TO

S. RES. 353, MARCH 5, 1980

Resolution Authorizing a Study of the Problems of the Aged and Aging

MAY 13 (legislative day, APRIL 27), 1981.—Ordered to be printed

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WASHINGTON : 1981

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LETTER OF TRANSMITTAL

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, D.C., May 13, 1981.

Hon. GEORGE BUSH,
President, U.S. Senate,
Washington, D.C.

DEAR MR. PRESIDENT: Under authority of Senate Resolution 353, agreed to March 5, 1980, I am submitting to you the annual report of the Senate Special Committee on Aging, Developments in Aging: 1980, Part 1.

Senate Resolution 4, the Committee Systems Reorganization Amendments of 1977, authorizes the Special Committee on Aging "to conduct a continuing study of any and all matters pertaining to problems and opportunities of older people, including, but not limited to, problems and opportunities of maintaining health, of assuring adequate income, of finding employment, of engaging in productive and rewarding activity, of securing proper housing and, when necessary, of obtaining care and assistance." Senate Resolution 4 also requires that the results of these studies and recommendations be reported to the Senate annually.

This report describes actions during 1980 by the Congress, the administration, and the Senate Special Committee on Aging which are significant to our Nation's older citizens. During the second session of the 96th Congress, Senator Lawton Chiles served as chairman of the Special Committee on Aging. The preparation and writing of this report was largely accomplished during 1980 under Senator Chiles' leadership. I deeply appreciate that extensive contribution and his continuing cooperation in completing this important report.

Therefore, on behalf of the members of the committee and its staff, I am pleased to transmit this report to you.

Sincerely,

JOHN HEINZ, *Chairman.*

SENATE RESOLUTION 353, 96TH CONGRESS, 2D SESSION [1]

Resolved, That the Special Committee on Aging, established by section 104 of S. Res. 4, Ninety-fifth Congress, agreed to February 4 (legislative day, February 1), 1977, is authorized from March 1, 1980, through February 28, 1981, in its discretion to provide assistance for the members of its professional staff in obtaining specialized training, in the same manner and under the same conditions as a standing committee may provide such assistance under section 202(j) of the Legislative Reorganization Act of 1946, as amended.

SEC. 2. In carrying out its duties and functions under such section and conducting studies and investigations thereunder, the Special Committee on Aging is authorized from March 1, 1980, through February 28, 1981, to expend $342,600 from the contingent fund of the Senate, of which amount (1) not to exceed $25,000 may be expended for the procurement of the services of individual consultants, or organizations thereof (as authorized by section 202(i) of the Legislative Reorganization Act of 1946, as amended), and (2) not to exceed $1,000 may be expended for the training of the professional staff of such committee (under procedures specified by section 202(j) of such act).

SEC. 3. The committee shall report its findings, together with such recommendations for legislation as it deems advisable, to the Senate at the earliest practicable date, but not later than April 30, 1981.

SEC. 4. Expenses of the committee under this resolution shall be paid from the contingent fund of the Senate upon vouchers approved by the chairman of the committee, except that vouchers shall not be required for the disbursement of salaries of employees paid at annual rate.

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[1] Agreed to March 5, 1980.

PREFACE

Since 1900, the average life expectancy in America has increased by more than 25 years. While no one would want to change this triumph of survivorship, it is producing a rapid increase in the aged members of our population. By the year 2000, 31.8 million Americans—12 percent of the population—will be over the age of 65. This so-called "graying of America" may not be the demographic dilemma of the proportions predicted by some alarmists. However, it does have significant political, economic, and social implications and many of these issues will demand resolution in the coming decade.

Three decades of expanding social services and income transfer programs for the elderly have greatly improved their economic status. Older persons have made gains in both absolute and relative income levels so that the poverty rate for older persons dropped from 33 percent in 1950 to 14 percent in 1978.

Without the social security program, it is estimated that 60 percent of the older population would live in poverty. Furthermore, inkind benefit programs such as food stamps, subsidized housing, and medicaid increase the average income of those on low incomes by 81 percent for single persons and 68 percent for couples. The impact of noncash transfers thereby brings the effective poverty rate down considerably.

Nevertheless, the most fundamental problem confronting older Americans today is the issue of economic security in a time of high inflation.

In 1980, the public was beginning to realize the enormous significance of the issue of providing an adequate income for the retired population. Federal expenditures for income security—largely retirement and disability programs—represent one-half of the Federal budget and are generally regarded as uncontrollable items.

The growing number of older people and the strain put on these systems by high unemployment and high inflation raises serious questions about how the Nation will continue to provide adequate retirement income in the future.

The Senate Special Committee on Aging has examined ways to increase the economic self-sufficiency of the aged through expanded options for employment and ways to assure the financial soundness of the social security retirement program. It has explored how to meet the real needs of the aged population without imposing unnecessary dependency.

The inflation rate reached unprecedented levels during 1980, so that even with a portion of their income indexed for inflation, the

overall incomes of older persons did not keep pace with rising prices. Energy bills alone consumed on the average 35 percent of the income of the low-income household. The return on prudent investments such as interest rates on small savings often did not keep pace with inflation.

The average annual increase in consumer prices during 1980 brought a 14.3-percent increase in social security checks and added almost $17 billion to the cost of the system.

Despite the expense of indexing benefit programs, median elderly incomes remained half those of younger persons. The 1979 poverty statistics revealed the rate had crept up to 15.1 percent from 14 percent the previous year—the first increase in the elderly poverty rate since 1975. Segments of the elderly population—notably minorities and women over the age of 75—were appallingly poor.

Elderly with reduced incomes found themselves paying much more for out-of-pocket medical expenses than younger families. Although Federal medicare payments totaled $41 billion, the program covered only about 38 percent of the elderly's medical bill.

At the same time the elderly, as a group, possessed great strength, resources, and assets—75 percent of older families owned their own homes, most of them, mortgage free. The elderly held approximately one-third of the Nation's personal savings. They comprised 11 percent of the population and paid about 10 percent of Federal income taxes. A larger percentage of the elderly had relatively high incomes than fell into the poverty category. Twenty percent of older families in 1979 had incomes above $20,000.

Almost 50 percent of elderly headed households reported some income from employment. Those who were employed had twice the average incomes of those who were not.

A number of trends which were emerging during 1980 appeared likely to set the pace for the early years of this decade.

Inflation, unless brought under control, threatened to put a permanent limitation on the ability of the Nation to meet its social goals.

Fiscal constraints required a more refined targeting of resources and a careful analysis of proposed new programs.

The escalating cost of health care and the fiscal solvency of social security loomed as the social policy and public expenditure issues of greatest significance to older persons.

Politicians, the public, and elderly persons themselves, continued to oppose age discrimination. It was recognized that while the aging process might sometimes result in poor health or lowered income status, age in and of itself should not be a barrier to anything.

With improvements in health and life expectancy, the older population represents a growing and invaluable source of experience and productivity.

To avoid unnecessary isolation, dependency, and unwelcome idleness; to seek a variety of opportunities for continued involvement; to strengthen individual choices and economic security in old age; these remained the challenge at the end of 1980.

JOHN HEINZ,
Chairman.
LAWTON CHILES,
Ranking Minority Member.

CONTENTS

EVERY NINTH AMERICAN

When we declared our independence, every 50th American was a so-called older person (aged 65 or over—65-plus). They came to some 50,000 out of an estimated total population of 2.5 million, or 2 percent.

By the beginning of this century, the numbers of older persons had increased much more rapidly than the young and they represented every 25th American (3.1 million or 4 percent of the 76 million total).

At the beginning of 1981, the over 25 million older Americans made up over 11 percent of the population—"Every Ninth American." [1]

But in recent years something uniquely different with new potentials for study and concern has become evident. In the past, the numbers of persons in all age groups increased even while the proportion of older persons in the population grew somewhat faster than did the younger age groups. Recent trends, however, have been different. Fertility rates since the end of the postwar baby boom have actually been below that necessary for zero population growth. A continuation of these trends over a lengthy period of time will bring us an aging society with an increasing median age and eventual declining total population by the middle of the 21st century.

Even cursory consideration indicates the enormous implications for retirement and income policies, the role of technology, the shifting of product markets and advertising, social and recreational facilities, location and types of housing, health care facilities and personnel, entertainment, etc.

What is the older population like, and how does it change?

GROWTH IN NUMBERS

During the 70 years between 1900 and 1970 (the last census), the total population of the United States grew almost threefold while the older part grew almost sevenfold.[2] The 65-plus population continues to grow faster than the under-65 portion: Between 1960 and 1970, older Americans increased in number by 21 percent as compared with 13 percent for the under-65 population; for 1970–79, the increase was 23.5 percent for the 65-plus group but only 6.3 percent for the under 65.

The most rapid growth (the largest percentage increases) in 1960–70 occurred in Arizona (79 percent), Florida (78.2), Nevada (70.4), Hawaii (51.3), and New Mexico (37.7), all States with significant

[1] This chapter has been prepared by Herman B. Brotman, consultant to the Special Committee on Aging, U.S. Senate, and former Assistant Commissioner on Aging, Department of Health, Education, and Welfare.

[2] Computed from reports of the 1900, 1960, and 1970 census enumerations, and estimates for 1979 prepared by the Census Bureau, using the 1970 counts as a base, and published in Current Population Reports.

numbers of older in-migrants. These five States and Alaska also had the fastest growth rates (over 50 percent) in 1970–79: Nevada (96.6 percent), Arizona (79.5), Florida (62.7), Hawaii (59.9), New Mexico (54.8), and Alaska (54.2).

Florida still has the highest proportion of older people—18.1 percent in 1979, 14.5 in 1970. Alaska remains the State with the smallest number and the smallest proportion of older persons—10,000 or 2.6 percent in 1979.

STATE HIGHLIGHTS

In mid-1979, the largest concentrations of older persons—13 percent or more of a State's population—occurred in six States: Florida (18.1), Arkansas (13.7), Iowa and South Dakota (13.1), Missouri and Nebraska (13).

California and New York each had more than 2 million older people, while Florida, Pennsylvania, Texas, Illinois, and Ohio each had more than 1 million.

Almost a quarter of the Nation's older people lived in just three States (California, New York, and Texas). Adding five more States (Pennsylvania, Illinois, Ohio, Michigan, and Florida) brings the eight-State total to almost half the older population of the United States. It takes 12 more States (New Jersey, Massachusetts, North Carolina, Indiana, Virginia, Georgia, Missouri, Wisconsin, Tennessee, Maryland, Minnesota, and Louisiana) or a total of 20 States to account for just over three-quarters of the older population. It requires an additional 10 States or a total of 30 to include 90 percent. The remaining 10 percent of the 65-plus population lives in the remaining 20 States and the District of Columbia. (See exhibit A, "Recent State Trends in the Older Population, 1970–79," for the actual figures and a detailed analysis.)

TURNOVER

The older population is not a homogeneous group nor is it static. Every day, approximately 5,000 Americans celebrate their 65th birthday. Every day, approximately 3,400 persons aged 65-plus die.[3] The *net* increase is about 1,600 per day or almost 600,000 per year, but the 5,000 "newcomers" each day are quite different from and have experienced a quite different life history than those already 65-plus and are worlds apart from those already centenarians who were born shortly after the Civil War.

AGE

As of mid-1980, most older Americans were under 75 (62.2 percent). Over half were under 73. And more than a third (34.9 percent) were under 70. Over 2.2 million Americans were 85 years of age or over.[4] As a result of the significantly longer life expectancy for females, the preponderance of women over men increases with age. (See "Sex Ratios" and "Projections.")

Accurate data on the number of centenarians are not available but 12,937 persons were receiving cash social security benefits in June

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[3] Computed from Census Bureau estimates of the components of population change.

[4] Computed from Census Bureau estimates in the Current Population Reports series, from National Center for Health Statistics reports on mortality and life expectancy in the Monthly Vital Statistics Reports series, and from estimates of centenarian beneficiaries supplied by the Social Security Administration.

1979, after producing some "proof of age" that indicated that they were then aged 100-plus. Further, sample studies of the file of persons covered by medicare produced an estimate of some 14,000 centenarians.

PERSONAL INCOME

Older economic units continue to have about half the income of their younger counterparts.[5] Retirement from the labor force usually brings a half to two-thirds cut in income and thrusts many older persons into a low-income category. Price inflation continues to present severe difficulties for older persons. Despite indexing of social security and some other benefit systems, much of the income of the elderly comes from sources which are not indexed, such as most private pension plan payments, commercial annuities, certain investments, such as bonds, and so forth.

Families

In 1979, half of the 8.8 million families headed by an older person had incomes of less than $11,316 ($218 a week) as compared with $21,201 ($408 a week) for the 49.6 million families with under-65 heads. Both medians represent an increase of about 11.5 percent over 1978, matching the increase in the Consumer Price Index and indicating no real change in purchasing power.

The skewing of the income distribution for older families toward the lower income levels is confirmed by the fact that the arithmetic average (mean) income of $14,730 is more than $3,400 or 30.2 percent greater than the median, $11,316, reflecting the impact of the high-income older families.

Thus, while the poverty rate for older families is high (see below), many have high incomes. More than 640,000 or 7.2 percent of older families had 1979 incomes of between $20,000 and $25,000; 1,010,000 or 11.5 percent had incomes between $25,000 and $50,000; and 182,000 or 2 percent had incomes in excess of $50,000. In summary, some 20 percent of the older families had higher incomes in 1979 than the median for younger families.

The importance of income from work (earnings) is shown by the fact that the 694,000 older families (7.9 percent of the total older families) whose heads were fully employed all year had double the median income of all older families ($22,852 versus $11,316) and almost double the mean income ($29,022 versus $14,730).

Unrelated Individuals

The 1979 median income of the 7.7 million unrelated individuals aged 65-plus who were living alone or with nonrelatives was $4,653 ($89 a week) as compared with $9,706 ($187 a week) for the 17.9 million aged 14 through 64 years old. The mean (arithmetic average) income for the older individuals was $6,541 or almost $1,900 or 40.6 percent higher than the median. Purchasing power, as compared with 1978, increased for the younger but decreased for the older individuals.

[5] Computed from data collected by the Census Bureau in the March 1980 monthly Current Population Survey on money income in 1979 and published in preliminary Current Population Reports. Detailed data (such as by type of family, by source of income, etc.) is not yet available.

Slightly over 1 million or 14.3 percent of the older unrelated individuals had 1979 incomes of $10,000 or more; and, of these, 150,000 or 2.1 percent of all older individuals had $25,000 or more.

Poverty

(*This analysis is based solely on cash money income and excludes consideration of services or noncash benefits and their impact on standard of living.*)

In 1979, the total number of persons of all ages living in households in which the total income was below the official poverty threshold for that size and type of household rose to 25.2 million (11.6 percent of the U.S. population) from 24.5 million (11.4 percent) in 1978. Some 3.6 million older persons (15.1 percent or about a seventh of the 65-plus population) were poor by the official definition (for example, $4,364 for a household of an older couple or $3,472 for an older individual living alone). The increase in the number of aged poor over 1978, when they numbered 3.2 million or 14 percent, was the first increase since 1975.

Women and minority elderly are heavily overrepresented among the aged poor, according to 1979 census data:

POVERTY RATES (PERCENT OF OLDER PERSONS IN EACH SEX, RACE, OR SPANISH ORIGIN CATEGORY LIVING IN POOR HOUSEHOLDS)

Sex	Total	White	Black	Spanish origin[1]
Both sexes	15.1	13.2	35.5	26.7
Male	11.1	9.5	26.9	23.8
Female	17.9	15.8	41.7	29.1

[1] May be of any race.

Nevertheless, this is a significant improvement over the 4.7 million or a quarter of the elderly who lived in "poor" households in 1970 and results primarily from the increases in social security benefits. It must also be recognized that many of the aged poor became poor after reaching these age levels because of the half to two-thirds cut in income that comes with retirement from the labor force. Cost reductions after retirement are usually considerably less than the income loss.

Application of a somewhat more liberal standard of low-income status, 125 percent of the official poverty threshold (used as an eligibility criterion in some programs) in 1979 produces an estimate of 35.4 million persons of all ages (16.3 percent of the total population) and a disproportionately larger 5.9 million 65-plus persons (24.7 percent of the elderly) who fall below this standard (for example, $5,455 for an older couple household and $4,340 for an older individual living alone).

Adequacy—The Retired Couple Budget

In the early 1960's, the Bureau of Labor Statistics, with the help of a group of experts, developed a theoretic retired couple budget to provide a modest but adequate standard of living for a retired couple consisting of a 65-plus husband and his wife, assumed to be self-supporting and living in an urban area, to be in reasonably good

health and able to take care of themselves, and to own a reasonable inventory of furniture and equipment.

Before 1969, the annual cost of the budget was calculated by actually pricing out all of the items in the budget and applying the appropriate "weighting." Since 1969, the cost of the budget is determined by applying to the cost for each division or component in the previous year the change in the comparable component of the Consumer Price Index for the urban wage earners and clerical workers. This procedure produces an approximation of unknown accuracy since spending patterns in the two measures are different as are the weights.

In 1979, the "intermediate" retired couple budget cost $8,562 ($165 a week). Of the 6.1 million two-person husband-wife families with 65-plus heads, about 2.2 million or 36 percent had less than this amount of income.

The cost of the lower budget, $6,023 ($116 a week), providing a reduced standard of living but well above the poverty level, could not be met by 1.1 million or 18.3 percent of these older couples.

The cost of the higher budget, $12,669 ($244 a week), providing some "luxury" items, gifts, contributions, and taxes, was beyond the income of 3.8 million or 62 percent of the 6.1 million older couples.[6]

INCOME MAINTENANCE

Old-Age, Survivors, and Disability Insurance

In July 1980, cash social security payments were sent to 35.1 million persons of all ages for a total of almost $10.5 billion.[7]

Of this total for the month, almost 30.4 million retired workers and their dependents or survivors received $9.2 billion from the old-age and survivors insurance trust fund, as follows:

	Number (thousands)	Amount (millions)
Retired workers	19,221	$6,510
Wives and husbands	2,992	511
Children	3,201	696
Widowed mothers	561	136
Widows and widowers	4,365	1,339
Parents (sole survivor)	15	4

And just under 100,000 special age-72 beneficiaries received $10.4 million.

Also, in July 1980, 4.7 million under-65 disabled workers and their dependents received almost $1.3 billion from the disability trust fund, as follows:

	Number (thousands)	Amount (millions)
Disabled workers	2,861	$1,059
Wives and husbands	467	52
Children	1,363	149

[6] Data on budget costs from bulletins of the Bureau of Labor Statistics. Number of couples within budget cost levels computed from unpublished Census Bureau data on 1979 money income, scheduled for later publication.

[7] Computed from data in selected issues of the monthly Social Security Bulletin and the Annual Statistical Supplements of the Social Security Administration.

Average monthly benefit, July 1980

Retired workers and their dependents:	
Retired workers [1]	$338.69
Wives and husbands	170.66
Children	137.03
Survivors of deceased workers:	
Children	236.90
Widowed mothers	242.27
Widows and widowers	306.73
Parents (sole survivor)	274.79
Disabled workers and their dependents:	
Disabled workers	370.04
Wives and husbands	110.54
Children	109.58
Special age-72 beneficiaries	104.37

[1] Almost 60 percent of all retired workers are receiving "reduced benefits" since they started drawing social security payments prior to reaching age 65. They represent a combination of voluntary "early retirements" and "discouraged workers" who have been unemployed and believe they cannot find employment.

BENEFICIARIES, BY AGE, JULY 1980

	Number (millions)	Percent distribution
All ages	35.1	100.0
Under 62	8.2	23.2
62 and over: Total	27.0	76.8
Retired workers	19.2	54.7
Disabled workers	.6	1.7
Dependents and survivors	7.0	20.1
Special age-72	.1	.3
62 to 64: Total	3.5	10.1
Retired workers	2.0	5.7
Disabled workers	.6	1.7
Dependents and survivors	.9	2.7
65 and over: Total	23.4	66.7
Retired workers	17.2	49.0
Dependents and survivors	6.1	17.4
Special age-72	.1	.3

During the month (July 1980), medicare disbursements totaled $2,986 million, of which $2,068 million, or close to 70 percent, was paid out under hospital insurance and $918 million under supplementary medical insurance. (See "Personal Health Care Expenditures.")

STATUS OF SOCIAL SECURITY INSURANCE TRUST FUNDS, JUNE 1980

[In millions of dollars]

Item	Old-age and survivors	Disability	Hospital	Supplementary medical
Receipts and interest	$6,655	$1,886	$3,075	$983
Payments	9,595	1,218	2,050	841
Administrative costs	84	29	38	43
Assets, end of month	27,515	7,507	14,678	4,657

As of the beginning of 1981, both the tax rate on covered earnings and the maximum amount of taxable wages are increased. (See further discussion of the social security program in chapter 3.)

Supplemental Security Income

In 1974, the Federal supplemental security income (SSI) needs-tested program replaced Federal-State assistance. The program sets up Federal payments to the aged, the blind, and the disabled, based on Federal eligibility and payment standards with automatic adjustments for increases in the Consumer Price Index.

States are encouraged to establish State supplement programs under their own laws and may then choose (1) to have the Federal Government pay the Federal payment and the State supplement in a single check to recipients in that State and bill the State for such supplementary payments, or (2) to make State payments separately to their own residents whether or not they receive Federal payments.

In July 1980, the Federal Government sent checks to 1,840,000 needy "aged" (65-plus) persons, totaling over $167,000,000 of Federal payments. An estimated additional 25,000 65-plus persons qualified for SSI as "blind" and 372,000 as "disabled"—both providing higher payment levels than for the "aged." Thus, while there were some 3.6 million older persons living in households where the income was below the poverty level in 1979, SSI payments were made to a total of 2.2 million.

In the 27 States which have arranged for the Federal Government to administer the State supplement, the combined checks went to some 1,205,000 65-plus persons and the State supplements totaled $69,118,000. The combined payments averaged a low of $73.10 in Maine to a high of $209.97 in California.

In the 23 States in which the State makes its supplementary payments directly to the recipient (a separate check in addition to the Federal payment), there were a total of 484,000 Federal recipients but only 138,400 State supplements totaling $9,613,000, averaging $69.45 per State recipient.

In the one State that pays no State supplement (Texas), Federal payments went to 150,000 "aged" recipients.

Seventeen States made State payments in July 1980 to 31,400 older persons who were not receiving Federal payments. These States paid out $2,495,000 or an average of $79.36.

HEALTH

National Health Expenditures

(Note: Includes personal health care, prepayment and administrative costs, governmental public health activities, and the costs of research and construction of medical facilities.)

NATIONAL HEALTH EXPENDITURES, ALL AGES[1]

	Calendar year		
	1979	1978	1965
Total:			
Amount (billions of dollars)	212.2	188.6	42.0
Per capita (dollars)	942.94	845.53	212.32
Percent of gross national product	9.0	8.9	6.1
Private sources:			
Amount (billions of dollars)	120.8	108.0	31.0
Per capita (dollars)	536.82	483.88	156.84
Percent of total	56.9	57.2	73.9
Public sources:			
Amount (billions of dollars)	91.4	80.7	11.0
Per capita (dollars)	406.12	361.64	55.48
Percent of total	43.1	42.8	26.1
Type of expenditure:			
Amount (billions of dollars):			
Total	212.2	188.6	42.0
Personal health care	188.6	166.6	36.0
Prepayment and administration	7.7	7.2	1.7
Government public health activities	6.1	5.3	0.8
Research	4.6	4.3	1.5
Construction of medical facilities	5.3	5.2	2.0
Percent distribution:			
Total	100.0	100.0	100.0
Personal health care	88.9	88.3	85.7
Prepayment and administration	3.6	3.8	4.1
Government public health activities	2.9	2.8	1.9
Research	2.2	2.3	3.4
Construction of medical facilitles	2.5	2.8	4.8

[1] Computed from data and estimates prepared by the Health Care Financing Administration.

Between the years 1965 (before medicare became effective) and 1979, the total health bill rose from $42 billion (6.1 percent of the GNP) to $212.2 billion (9 percent of the GNP). This quintupling of total costs in 14 years results from technological changes, very rapid increases in prices and labor costs, the impact of the growth and "aging" of the older population, and increased utilization made possible by increased resources, especially through public programs. Nursing home, hospital, and physician costs, all exceptionally important to health care of the elderly were among the most rapidly rising areas.

Personal Health Care Expenditures

(Note: Excludes prepayment and administrative costs, cost of research and construction of medical facilities, and governmental public health activities such as control of contagious diseases.)

Total personal health care expenditures rose from $37.3 billion or $188.43 per capita in 1965 to $167.9 billion or $752.98 per capita in 1978. The estimate for 1979 is $188.6 billion but age distributions are not yet available. It is estimated that if the 1979 figure were adjusted for price increases the 13.2 percent increase over 1978 would be reduced to 3.6 percent.

For the 65-plus population, total health care costs came to $49.4 billion; for the under-65, it came to $118.5 billion. On a per capita basis, however, the $2,026.19 for an older person was 3.4 times the $596.82 for an under-65 individual. Of the $49.4 billion for older persons, $18.2 billion or 37 percent came from private funds and $31.2 billion or 63 percent from public programs. Of the total public outlays, $26.8 billion or 86 percent came from Federal programs and $4.4 billion or 14 percent from State and local programs.

ANALYSIS OF PERSONAL HEALTH CARE EXPENDITURES, BY TYPE OF EXPENDITURE, SOURCE OF FUNDS, AND AGE GROUP, 1978

Type of expenditure	All ages	Under 65	65 and over				
			Total	Private	Public		
					Total	Federal	State/local
Amount (total, millions of dollars)	167,911	118,545	49,366	18,192	31,175	26,780	4,395
Hospital care	76,025	54,856	21,169	2,645	18,524	17,165	1,359
Physicians' services	35,250	26,340	8,910	3,620	5,290	5,120	170
Dentists' services	13,300	11,917	1,383	1,338	45	28	17
Other professional services	4,275	3,185	1,090	631	459	421	38
Drugs and drug sundries	15,098	11,867	3,231	2,728	503	264	239
Eyeglasses and appliances	3,879	3,274	605	405	201	199	2
Nursing home care	15,751	3,127	12,624	6,790	5,834	3,336	2,498
Other health services	4,333	3,979	354	35	319	247	72
Per capita (total, dollars)	752.98	596.82	2,026.19	746.68	1,279.55	1,099.16	180.39
Hospital care	340.93	276.17	868.86	108.56	760.30	704.52	55.78
Physicians' services	158.08	132.61	365.70	148.58	217.12	210.15	6.98
Dentists' services	59.64	60.00	56.76	54.92	1.85	1.15	.70
Other professional services	19.17	16.03	44.74	25.90	18.84	17.28	1.56
Drugs and drug sundries	67.70	59.74	132.61	111.97	20.64	10.84	9.81
Eyeglasses and appliances	17.40	16.48	24.83	16.62	8.25	8.17	.08
Nursing home care	70.64	15.74	518.14	278.69	239.45	136.92	102.53
Other health services	19.43	20.03	14.53	1.44	13.10	10.14	2.96
Percent distribution by type of expenditure (total)	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	45.3	46.3	42.9	14.5	59.4	64.1	30.9
Physicians' services	21.0	22.2	18.0	19.9	17.0	19.1	3.9
Dentists' services	7.9	10.0	2.8	7.4	0.1	0.1	0.4
Other professional services	2.5	2.7	2.2	3.5	1.5	1.6	0.9
Drugs and drug sundries	9.0	10.0	6.5	15.0	1.6	1.0	5.4
Eyeglasses and appliances	2.3	2.8	1.2	2.2	0.6	0.7	----
Nursing home care	9.4	2.6	25.6	37.3	18.7	12.5	56.8
Other health services	2.6	3.4	0.7	0.2	1.0	0.9	1.6
Percent distribution by source of funds and age (total)	100.0	70.6	29.4 100.0	36.9	63.1 100.0	85.9	14.1
Hospital care	100.0	72.2	27.8 100.0	12.5	87.5 100.0	92.7	7.3
Physicians' services	100.0	74.7	25.3 100.0	40.6	59.4 100.0	96.8	3.2
Dentists' services	100.0	89.6	10.4 100.0	96.7	3.3 100.0	62.2	37.8
Other professional services	100.0	74.5	25.5 100.0	57.9	42.1 100.0	91.7	8.3
Drugs and drug sundries	100.0	78.6	21.4 100.0	84.4	15.6 100.0	52.5	47.5
Eyeglasses and appliances	100.0	84.4	15.6 100.0	66.8	33.2 100.0	99.0	1.0
Nursing home care	100.0	19.9	80.1 100.0	53.8	46.2 100.0	57.2	42.8
Other health services	100.0	91.8	8.2 100.0	9.9	90.1 100.0	77.4	22.6

Hospital care was the largest item by far in health care of older persons. The $21.2 billion ($868.86 per capita) for hospital payments used 43 percent of the total expenditures. Some $18.5 billion or almost 88 percent of these hospital payments came from public programs (of which 93 percent were Federal funds).

The next largest expenditure for older persons, nursing home care in 1978, came to $12.6 billion or $518.14 per capita (as compared with $4.1 billion or $204.87 per capita in 1970). The 1978 figure represents almost 26 percent of the total health bill for older persons, with 46 percent paid by public agencies (of which 57 percent was Federal money and 43 percent State and local).

The third largest expenditure, physicians' services, totaled $8.9 billion or $365.70 per capita. This was 18 percent of total expenditures for older persons; 60 percent was paid by public programs, 97 percent of which was Federal.

The other five categories of expenditures each accounted for less than 7 percent of the total. Noteworthy is the fact that in four (dentists' services, other professional services, drugs and drug sundries, and eyeglasses and appliances) of the five categories (fifth is other health services) private payments accounted for between 58 and 97 percent of the costs, reflecting to a very large extent the fact that these services and supplies are not usually provided by public programs.

Data for a comparison of levels and sources of payments that indicate the role of direct out-of-pocket, insurance, and philanthropic sources on a per capita basis for 1966 (the year medicare became effective) and a recent year are not yet available. The following presents unrevised data from last year's version of "Every Ninth American":

Age and fiscal year	Total	Direct out-of-pocket	Third-party payments			
			Total	Government	Private health insurance	Philanthropy and industry
Amount:						
Under 65:						
1966	$155	$79	$76	$30	$42	$3
1977	514	164	350	150	187	13
65-plus:						
1966	445	237	209	133	71	5
1977	1,745	462	1,283	1,169	101	12
Distribution (percent):						
Under 65:						
1966	100	51.1	48.9	19.4	27.3	2.2
1977	100	31.9	68.1	29.1	36.4	2.6
65-plus:						
1966	100	53.2	46.8	29.8	15.9	1.1
1977	100	26.5	73.5	67.0	5.8	.7

This comparison shows both a significant increase in utilization as well as a doubling of health care prices, with a pronounced shift toward third-party payment arrangements, especially through public programs. The nominal dollar increase in out-of-pocket payments by older persons loses significance if allowance is made for the rapid price increases for the same amount of care plus the actual increase in utilization.

EXPENDITURES BY PUBLIC PROGRAMS IN PERSONAL HEALTH CARE FOR PERSONS AGED 65 AND OVER, BY PROGRAM, 1978

[In millions of dollars]

Program	Total	Federal	State/local
Total	31,175	26,780	4,395
Medicare	21,775	21,775	0
Medicaid	6,611	3,684	2,927
Other medical public assistance	391	0	391
Veterans' Administration	1,053	1,053	0
Department of Defense	131	131	0
Workers compensation	93	4	89
State and local hospitals (net)	942	0	942
All other	182	136	46

Older persons comprised slightly over 11 percent of the total population in 1978 but accounted for 29.4 percent of the personal health care costs. Some 63 percent of the total payments for persons 65-plus came from public programs with 91 percent coming from medicare (69.8) and medicaid (21.2).

Health Status

In a recent household interview survey of a sample of the noninstitutionalized population, over two-thirds (69 percent) of the older persons reported their health good or excellent as compared with "others of their own age." Almost 22 percent reported their health as fair and 9 percent as poor. Minority group members, residents of the south, residents of nonmetropolitan areas, and persons with low incomes were more likely to report themselves in poor health.[8]

Counting the approximately 5 percent of older people who live in institutions as being in poor health, a total of about a seventh (14 percent) of all older people consider themselves in poor health.

In 1979 (based on the new Ninth Revision of the International Classification of Diseases), the most frequently reported chronic conditions reported by the noninstitutionalized elderly were: Arthritis (44 percent), hypertension (39 percent), hearing impairment (28 percent), heart conditions (27 percent), and visual impairments and arteriosclerosis (each about 12 percent).

In the 1979 survey, almost half (46 percent) of the 65-plus respondents said they had some limitation on their "usual" activity because of a chronic condition. About 17 percent were unable to perform their usual activity at all, 22 percent reported limitation in the amount or kind of usual activity, and about 7 percent were limited outside the usual activity.

A 1977 study showed that of the over 22 million older persons not in institutions, 2.1 percent were confined to bed, 2.6 percent needed help to get about in the house, 6 percent needed help to get about in the neighborhood and 8.4 percent needed help outside the neighborhood. In terms of needing help in daily functions, 3.8 percent needed help with bathing, 2.6 percent needed help with dressing, 0.8 percent with eating, and 1.4 percent with toilet. (See the table below for a cross-

[8] Computed from published and unpublished data supplied by the National Center for Health Statistics, based on the Household Interview Survey, the Hospital Discharge Survey, the Nursing Home (Health Facilities) Survey, etc.

tabulation of these two kinds of "helps" and an analysis of the differences by age groups within the 65-plus population. This is especially significant in view of the current concern over long-term or continuing care and the rapid growth in the oldest part of the older population, since the need for both types of "helps" increases markedly with age.)

IMPACT OF DISABILITY RESULTING FROM CHRONIC CONDITIONS, PERSONS AGED 65 AND OVER, 1977

[Numbers in thousands]

Help needed	Noninstitutional population	Confined to bed	Needs help		
			In house	In neighborhood	Outside neighborhood
65-plus:					
Total	22,266	459	573	1,331	1,862
Percent	100.0	2.1	2.6	6.0	8.4
Percent[1]	100.0	100.0	100.0	100.0	100.0
Needs help:					
Bathing	853	302	494		
Percent[1]	3.8	65.9	77.4		
Dressing	582	249	371		
Percent[1]	2.6	54.3	64.6		
Eating	186	115	150		
Percent[1]	0.8	25.0	26.1		
Toilet	318	183	273		
Percent[1]	1.4	39.9	47.6		
65 to 74:					
Total	14,259	204	202	447	649
Percent	100.0	1.4	1.4	3.1	4.6
Percent[1]	100.0	100.0	100.0	100.0	100.0
Needs help:					
Bathing	293	117	161		
Percent[1]	2.1	57.2	80.0		
Dressing	215	101	143		
Percent[1]	1.5	49.9	70.8		
Eating	73	38	59		
Percent[1]	0.5	18.4	29.1		
Toilet	123	72	107		
Percent[1]	0.9	35.3	52.8		
75 to 84:					
Total	6,652	173	225	554	799
Percent	100.0	2.6	3.4	8.3	12.0
Percent[1]	100.0	100.0	100.0	100.0	100.0
Needs help:					
Bathing	355	117	166		
Percent[1]	5.3	67.4	73.9		
Dressing	238	86	132		
Percent[1]	3.6	49.7	58.8		
Eating	59	38	47		
Percent[1]	0.9	22.2	21.0		
Toilet	105	51	90		
Percent[1]	1.6	29.6	39.9		
85-plus:					
Total	1,355	81	146	331	414
Percent	100.0	6.0	10.8	24.4	30.6
Percent[1]	100.0	100.0	100.0	100.0	100.0
Needs help:					
Bathing	205	69	116		
Percent[1]	15.1	84.6	79.0		
Dressing	129	61	95		
Percent[1]	9.5	75.5	65.2		
Eating	53	39	44		
Percent[1]	3.9	47.8	30.0		
Toilet	91	60	77		
Percent[1]	6.7	73.3	52.4		

[1] Percent of column total for this age group.

Utilization

Older people are subject to more disability, see physicians about 50 percent more often, and have about twice as many hospital stays that last almost twice as long as is true for younger persons. Still, some 82 percent reported no hospitalization in the previous year.

In 1978, the average length of stay in a short-stay hospital for persons with one or more hospital stays was 7 days for all ages and 10.4 for those 65 and over. Averaging together those with hospital stays and the vast majority with no stays, the average number of hospital days was 1.9 for ages 55–64, 3.2 days for ages 65–74 and 6 days for those 75-plus. Using the same averaging approach for persons with and without nursing home stays, a 1976 survey showed a fraction of 1 day in a nursing home for persons aged 55–64, 4.4 days for those aged 65–74, a jump to 21.5 days for those aged 75–84 and to 86.4 days for the 85-plus.

Of the 1.1 million older people in nursing homes at the time of a 1977 study, 19 percent were aged 65–74, 41 percent were 75–84, and 40 percent were 85-plus—in the total older population, the comparable percentages were 62, 29, and 9. In the nursing home population, 74 percent were women (60 percent in the total older population), 69 percent were widowed, 14 percent were single, and 12 percent were married; 93 percent were white. Of every 100 residents in nursing homes, almost 40 came from their own residences (only 14 had been living alone), 32 came from general hospitals, 13 from other nursing homes or related facilities, and the rest (about 15) came from a variety of mental and other health facilities.

SELECTED DATA FROM THE 1979 HOUSEHOLD SURVEY OF THE NONINSTITUTIONAL POPULATION

	All ages	65-plus
Restricted-activity days per person per year	19.0	41.9
Bed-disability days per person per year	6.7	13.7
Number of acute conditions per person per year	2.2	1.1
Number of physician visits per person per year:		
Total	4.7	6.3
In doctor's office, clinic, or group practice	3.2	4.6
In hospital outpatient department or emergency room	.6	.7
By telephone	.6	.7
Interval since last physician visit (percent distribution of persons):		
Less than 1 yr	75.1	79.8
Under 6 mo	58.5	69.4
6 to 11 mo	16.5	10.4
1 yr	10.9	5.7
2 to 4 yr	9.3	7.8
5-plus yr	3.5	5.9
Never	.2	.1
Number of dental visits per person per year	1.7	1.4
Interval since last dental visit (percent distribution of persons):		
Less than 1 yr	50.2	32.8
Under 6 mo	35.6	24.4
6 to 11 mo	14.5	8.4
1 yr	13.1	7.6
2 to 4 yr	12.7	13.7
5-plus yr	13.6	43.7
Never	9.1	.7
Short-stay hospital discharges per 100 persons per year	13.9	27.0
Average length of stay (days)	7.8	10.8
Number of hospital episodes per year (percent distribution of persons):		
None	89.7	81.8
1 episode	8.5	13.9
2 episodes	1.3	3.0
3-plus episodes	.5	1.3
Average length of stay for persons with hospital stays by number of episodes:		
Total, all episodes	9.6	14.3
1 episode	6.6	10.1
2 episodes	17.5	22.2
3-plus episodes	37.6	40.4

Death Rates

Death rates for every age group and both sexes have been declining since 1950 except for 15 to 24-year-old males.[9] Between 1977 and 1978,

[9] Computed from mortality data prepared by the Vital Statistics Division of the National Center for Health Statistics and based on the death certificate reporting system.

death rates declined except for males aged 1–4, females aged 5–9, and both males and females aged 15–24 and 75–84.

In the period between 1965 and 1978, annual death rates for older persons dropped about 12 percent from 6 per 100 to 5.3 per 100. Within the older population, the rate for persons 65–74 dropped 19 percent from 3.7 to 3.1 per 100, the rate for those 75–84 declined 14 percent from 8.4 to 7.2 per 100, while the rate for the 85-plus dropped 27 percent from 20.1 to 14.7 per 100.

The rate for deaths of older persons from heart disease dropped 18 percent, from 2.8 to 2.3 per 100. The death rate from stroke fell 33 percent, from 0.9 to 0.6 per 100 but the rate for deaths from cancer increased 11 percent, from 0.9 to 1. These declines in death rates accelerated the more recent increases in life expectancy in the upper ages.

Heart disease, stroke, and cancer accounted for three-quarters of the deaths of older persons in 1978 as they did in 1965. The following table analyzes the number and proportion of deaths accounted for by the major causes of death in 1978 for all ages and for 10-year age groupings in the middle and upper age groups. Particularly noteworthy are the increasing proportions of deaths from heart disease and stroke with advancing age (also true at a lower level for influenza and pneumonia) but the sharp drop in the proportion of deaths caused by cancer. While accidental deaths have traditionally been most prevalent among the younger, the more recent increase in suicides among the very young have overshadowed the situation for the aged.

SELECTED MAJOR CAUSES OF DEATH IN 1978, ALL AGES AND AGE GROUPS OVER 45

Cause	Number (thousands)						Percent distribution[1]					
	All ages	45–54	55–64	65–74	75–84	85+	All ages	45–54	55–64	65–74	75–84	85+
All causes	1,928	141	293	452	497	324	100.0	100.0	100.0	100.0	100.0	100.0
Major cardiovascular diseases (total)	966	51	128	233	304	227	50.1	36.6	43.9	51.5	61.1	70.0
Diseases of the heart	730	44	108	184	221	156	37.8	30.9	36.8	40.7	44.4	48.2
Cerebrovascular diseases	176	6	15	36	63	50	9.1	4.5	5.2	8.0	12.7	15.5
Arteriosclerosis	29	(2)	1	4	10	14	1.5	.2	.3	.8	2.0	4.3
Other	32	1	4	9	10	6	1.7	1.0	1.6	2.0	2.0	2.0
Malignant neoplasms	397	43	91	120	90	32	20.6	30.2	31.2	26.4	18.0	9.9
Influenza and pneumonia	58	2	5	10	18	19	3.0	1.6	1.7	2.2	3.6	5.7
Diabetes mellitus	34	2	6	10	10	5	1.8	1.6	1.9	2.1	2.0	1.4
Accidents	106	9	10	9	9	6	5.5	6.5	3.3	2.0	1.8	1.9
Suicides	27	4	4	3	2	(2)	1.4	2.8	1.3	.6	.3	.1
All other	340	29	49	69	65	36	17.6	20.7	16.7	15.2	13.2	11.0

[1] Computed from numbers before rounding to nearest thousand.
[2] Less than 500.

HOUSING

The 1976 annual housing survey showed 14.8 million elderly households (households with heads aged 65-plus) and they constituted 20 percent of the total 74.1 million households in the United States.[20]

[10] Basic data from special analyses of the Annual Housing Survey of the Department of Housing and Urban Development, from research organization retabulation of the survey data, and from selected administrative summaries of program activities.

Broad measures of housing conditions showed many similarities between the elderly and the younger households but there were differences in many of the details arising from the somewhat lower proportion of the elderly living in metropolitan areas, their concentration in the inner city, their generally lower income level, the greater age of their homes and the accompanying maintenance problems and costs, the presence of excess space as maturing family members leave their parents' homes, etc. In general, about 90 percent of housing was evaluated as "adequate."

The traditional rule of thumb is that housing should not cost more than 25 percent of income. In the 1976 survey, it was found that 80.3 percent of all households and only 58.7 percent of elderly households could "afford" adequate housing if they spent under 25 percent of their income. For owners, the percentages were 84.3 percent for all and 62.2 percent for the elderly; for renters, 72.8 and 50.1 percent. In fact, in 1976, 32 percent of all households spent more than 25 percent of their income for housing while 35 percent of the elderly did so—65 percent of renters and 23 percent of owners.

Homeownership is more prevalent among the aged than the younger households (70.6 versus 63.3 percent) and an estimated 84 percent of the elderly had paid off their mortgages completely.

The elderly tend to live in much older structures than do younger families. Almost 60 percent of the elderly households live in structures built before 1950 as compared with 40 percent for the younger. Prewar housing is occupied by 47.1 percent of the older households and only 30.2 percent of the younger.

While the totals for flawed or inadequate housing were rather similar (about 10 percent in each case), older households had more problems with plumbing, kitchens, and sewage, while the younger had more problems with maintenance and toilet access (the latter because of the presence of children under 18).

As expected, household income, value of owned home, and monthly rental are considerably larger for all households than for the older households; moreover, it must be remembered that some other costs, like food and health care, absorb larger proportions of the incomes of older households.

While older households, like all households, have about one chance in ten of being inadequately housed, black and Hispanic families have only one chance in five of enjoying adequate housing. In the worst case, a poor Hispanic man aged 65-plus and living alone has less than one chance in two (a probability of 0.56 as compared with 0.43 for a poor elderly black man).

COMPARISON OF CHARACTERISTICS OF HOUSEHOLDS WITH UNDER-65 AND 65-PLUS HEADS, 1976

[Percent distributions]

Characteristic	Heads under 65	Heads 65-plus	Characteristic	Heads under 65	Heads 65-plus
Total households	100.0	100.0	Total households	100.0	100.0
Tenure:			Type of heating equipment:		
Homeowner	63.3	70.6	Central	54.6	43.5
Cash rent	34.5	26.4	Steam	17.8	20.6
No cash rent	2.2	3.0	Electric	6.6	6.0
Year structure built:			Floor, wall	8.5	9.4
After March 1970	17.5	7.7	Room heater	5.4	9.5
1965 to 70	13.1	8.9	Other/inadequate	7.1	11.0
1960 to 64	11.1	7.5	Air-conditioning	53.8	46.6
1950 to 59	18.4	16.2	Alterations during year ($100 plus)	10.5	4.7
1940 to 49	9.6	12.6	Water source:		
1939 or earlier	30.2	47.1	Public or private	83.5	83.5
Units in structure:			Individual well	15.0	14.8
1	68.7	67.1	Other	1.5	1.7
2 to 4	12.4	12.8	Electricity:		
5 or more	13.9	15.1	Yes	99.8	99.8
Mobile home	5.0	4.9	No	.2	.2
Hotel or rooming house	.3	.5	Type of sewage disposal:		
Number of bathrooms:			Public sewer	73.1	73.2
None or shared	2.1	4.6	Septic tank/cesspool	25.9	24.4
1 but separated	.3	.6	Chemical toilet		
1	58.9	70.1	Privy	.9	2.0
1.5	14.9	11.9	Other	.1	.4
2	16.7	10.2			
3 or more	7.1	2.6			

CHARACTERISTICS OF HOUSEHOLDS WITH 65-PLUS HEADS, 1976

Characteristic	Number (thousands)			Percent distribution			Percent of total	
	Total	Metropolitan area	Nonmetropolitan area	Total	Metropolitan area	Nonmetropolitan area	Metropolitan area	Nonmetropolitan area
Total households	14,827	9,301	5,525	100.0	100.0	100.0	62.7	37.3
Tenure:								
Homeowner	10,469	6,118	4,352	70.6	65.8	78.8	58.4	41.6
Cash rent	3,913	2,990	923	26.4	32.1	16.7	76.4	23.6
No cash rent	445	194	251	3.0	2.1	4.5	43.6	56.4
Year structure built:								
After March 1970	1,142	721	421	7.7	7.8	7.6	63.1	36.9
1965–70	1,318	820	498	8.9	8.8	9.0	62.2	37.8
1960–64	1,109	708	401	7.5	7.6	7.2	63.8	36.2
1950–59	2,399	1,583	815	16.2	17.0	14.8	66.0	34.0
1940–49	1,876	1,224	653	12.6	13.2	11.8	65.2	34.8
1939 or earlier	6,983	4,245	2,737	47.1	45.6	49.5	60.8	39.2
Units in structure:								
1	9,951	5,431	4,519	67.1	58.4	81.8	54.6	45.4
2 to 4	1,905	1,441	464	12.8	15.5	8.4	75.6	24.4
5 or more	2,243	2,027	216	15.1	21.8	3.9	90.4	9.6
Mobile home	729	402	327	4.9	4.3	5.9	55.1	44.2
Hotel or rooming house	76	59	17	.5	.6	.3	77.6	22.4
Number of bathrooms:								
None or shared	680	221	459	4.6	2.4	8.3	32.5	67.5
1 bath but separated	93	76	18	.6	.8	.3	81.7	19.3
1	10,390	6,532	3,859	70.1	70.2	69.8	62.9	37.1
1.5	1,760	1,123	637	11.9	12.1	11.5	63.8	36.2
2	1,511	1,060	451	10.2	11.4	8.2	70.2	29.8
3 or more	392	290	102	2.6	3.1	1.8	74.0	26.0

CHARACTERISTICS OF HOUSEHOLDS WITH 65-PLUS HEADS, 1976—Continued

Characteristic	Number (thousands)			Percent distribution			Percent of total	
	Total	Metropolitan area	Nonmetropolitan area	Total	Metropolitan area	Nonmetropolitan area	Metropolitan area	Nonmetropolitan area
Type of heating equipment:								
Central	6,450	4,155	2,295	43.5	44.7	41.5	64.4	35.6
Steam	3,063	2,554	509	20.6	27.4	9.2	83.4	16.6
Electric	890	523	368	6.0	5.6	6.7	58.8	41.2
Floor, wall	1,394	874	520	9.4	9.4	9.4	62.7	37.3
Room heater	1,405	578	827	9.5	6.2	15.0	41.1	58.9
Other/inadequate	1,625	618	1,007	11.0	6.6	18.2	38.0	62.0
Air-conditioning	6,914	4,565	2,349	46.6	49.1	42.5	66.0	34.0
Alterations during year ($100 plus)	699	441	258	4.7	4.7	4.7	63.1	36.9
Water source:								
Public or private	12,385	8,612	3,773	83.5	92.6	68.3	69.5	30.5
Individual well	2,188	644	1,544	14.8	6.9	27.9	29.4	70.6
Other	253	45	209	1.7	.5	3.8	17.7	82.3
Electricity:								
Yes	14,795	9,291	5,505	99.8	99.9	99.6	62.8	37.2
No	31	10	21	.2	.1	.4	32.3	67.7
Type of sewage disposal:								
Public sewer	10,848	7,935	2,913	73.2	85.3	52.7	73.1	26.9
Septic tank/cesspool	3,622	1,302	2,319	24.4	14.0	42.0	36.0	64.0
Chemical toilet	7	4	3					
Privy	294	45	249	2.0	.5	4.5	15.3	84.7
Other	57	15	42	.4	.2	.8	26.3	73.7

HOUSEHOLD INCOME, VALUE OF HOME, AND MONTHLY RENTAL, 1977

[Numbers in thousands]

Type of household	Owner occupied				Renter occupied			
	All ages		65-plus		All ages		65-plus	
	Number	Median	Number	Median	Number	Median	Number	Median
	Household income							
All households	48,765	$16,000						
2-plus person households	42,088	17,600			17,395	$10,000		
Husband-wife	36,274	18,500	5,551	$9,200	10,748	12,100	1,119	$7,100
Other male head	1,775	15,400	390	9,700	1,943	9,300	97	6,500
Female head	4,039	10,100	952	7,800	4,705	5,800	384	5,000
1-person household	6,677	5,800			9,119	6,300		
Male head	1,988	9,800	748	5,100	4,048	8,600	724	4,100
Female head	4,689	4,900	2,989	4,300	5,071	4,900	2,080	3,700
	Value of home				Monthly rental			
All households	38,754	$36,900						
2-plus person households	34,058	38,200			16,806	$197		
Husband-wife	29,459	39,100	4,013	$32,500	10,239	201	1,069	$178
Other male head	1,344	36,400	301	28,900	1,908	217	92	154
Female head	3,254	30,500	739	26,200	4,608	184	374	149
1-person household	4,696	27,100			9,010	160		
Male head	1,321	28,500	528	24,000	3,967	159	698	98
Female head	3,375	26,700	2,168	25,700	5,043	160	2,063	153

SUMMARY OF HUD ELDERLY HOUSING PROGRAM ACTIVITIES

Type of program and section number of act	Program	Status	Number of projects	Number of units	Value (millions)	Estimated number of elderly units	Percent elderly units	Period covered
Construction:								
3, 4, title II	Low-income public housing	Active	10, 750	1, 200, 000	NA	[1] 552, 000+	46	Through Sept. 30, 1979.
202	Direct loans for housing for the elderly and the handicapped.	Inactive [2]	330+	45, 275	$574.6	45, 275	100	Through 1972.
		Active [3]	1, 211	91, 716	3, 325.1	87, 522	95	Through May 31, 1980.
231	Mortgage insurance for housing for the elderly	Active	477	64, 116	1, 083.0	64, 116	100	Through Dec. 1979.
221(d)3	Multifamily rental housing for low- and moderate-income families.	do	3, 417	346, 383	5, 337.5	55, 602	7	Do.
221(d)4		do	3, 874	447, 938	8, 939.9			Do.
235	Homeownership assistance for low- and moderate-income families.	Inactive [2]	[4] 472, 059	473, 032	8, 456.7			Through revision.
		Active	40, 862	40, 893				Revision through May 1980.
207	Multifamily rental housing	do	2, 639	285, 108	3, 937.7	3, 421	1	Through Dec. 1979.
236	Rental and cooperative assistance for lower income families.	Inactive	4, 052	434, 645	7, 480.0	53, 799	12	Through Dec. 1978.
202/236	202/236 conversion	do	182	28, 306	482.0	28, 306	100	Do.
232	Nursing homes and intermediate care facilities	Active	1, 271	145, 262	1, 581.6	145, 262	100	Through Dec. 1979.
Nonconstruction:								
8	Low-income rental assistance:							
	Existing [5]	do	9, 446	821, 418	NA	240, 742	29	Through May 31, 1980.
	New construction [5 6]	do	8, 393	538, 561	NA	290, 447	54	Do.
	Substantial rehabilitation [5 6]	do	1, 650	112, 828	NA	40, 107	35	Do.
312	Rehabilitation loans	do [7]	75, 913	NA	780.2	NA	25	Through Sept. 30, 1979.
23	Low rent leased housing	Inactive [2]	NA	163, 267	NA	54, 000+	35+	Through Dec. 1975.

[1] Number of units designed specifically for the elderly is not available.
[2] Figures for original program reported through program revision.
[3] Figures for revised sec. 202/8 represent cumulative project reservations as of May 31, 1980.
[4] Figures represent number of mortgages.
[5] Figures represent cumulative fund reservations through reporting date.
[6] Figures do not include sec. 8 commitments attached to sec. 202/8 fund reservations.
[7] Figures represent loan commitments only.

LIFE EXPECTANCY

Life expectancy (average remaining years of life) reached new highs for the United States. The total for both sexes combined was 73.3 years but the 77.2 years for females was 7.7 years longer than the 69.5 for males.[11]

At age 65, the combined expectancy was 16.3 years with the 18.4 years for women exceeding by 4.4 years the remaining years for men,14.

The 26-year or 55-percent increase in life expectancy at birth since 1900 (when it was 47.3) results to a large extent from the wiping out of most of the killers of infants and of the young. Only since midcentury has life expectancy in the upper ages begun to improve as death rates from the killers of older persons, chronic conditions and diseases, began to decrease. Thus, during the first half of this century, growing numbers of persons reached older ages but once there, did not live much longer than did their ancestors who reached such age. Since the 1950's, life expectancy at the upper ages has also increased and current decreases in death rates from cardiovascular conditions portend further added years of life.

The gap between whites and "others" (primarily black) in life expectancy at birth has narrowed in recent decades. Also, for those who do reach advanced age, about at the age of 70, life expectancy is slightly higher for those in the category "others" than for whites.

The tables below analyze in detail the changes in life expectancy by sex and color at selected ages for selected years between 1900 and 1980, the translation of these trends into estimates of the number of babies born in 1900 and 1978 expected to reach selected ages (for example, about 40 percent of babies born in 1900 were expected to reach age 65 as compared with 76 percent for 1978), and a listing of the 25 countries having the highest male and female life expectancies as reported by the United Nations.

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[11] Computed from basic data on mortality and life expectancy published by the Vital Statistics Division of the National Center for Health Statistics. Simulated projections prepared by the author.

LIFE EXPECTANCY (AVERAGE REMAINING YEARS OF LIFE) AT SELECTED AGES, 1900–78

Age and year	Total			White			Other		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
At birth:									
1900	47.3	46.3	48.3	47.6	46.6	48.7	33.0	32.5	33.5
1910	50.0	48.4	51.8	50.3	48.6	52.0	35.6	33.8	37.5
1920	54.1	53.6	54.6	54.9	54.4	55.6	45.3	45.5	45.2
1930	59.7	58.1	61.6	61.4	59.7	63.5	48.1	47.3	49.2
1940	62.9	60.8	65.2	64.2	62.1	66.6	53.1	51.5	54.9
1950	68.2	65.6	71.1	69.1	66.5	72.2	60.8	59.1	62.9
1960	69.7	66.6	73.1	70.6	67.4	74.1	63.6	61.1	66.3
1970	70.9	67.1	74.8	71.7	68.0	75.6	65.3	61.3	69.4
1978	73.3	69.5	77.2	74.0	70.2	77.8	69.2	65.0	73.6
Increase 1900–78:									
Years	26.0	23.2	28.9	26.4	21.6	29.1	36.2	32.5	40.1
Percent	55.0	50.1	59.8	55.5	44.4	59.8	109.7	100.0	119.7
At age 20:									
1900					42.2	43.8		35.1	36.9
1920					45.6	46.5		38.4	37.2
1940					47.8	51.4		39.7	42.1
1960					50.3	56.3		45.8	50.1
1978	55.0	51.4	58.7	55.5	52.0	59.1	51.5	47.4	55.6
Increase 1900–78:									
Years					9.8	15.3		12.3	18.7
Percent					23.2	34.9		35.0	50.7
At age 45:									
1900					24.2	25.5		20.1	21.4
1920					26.0	27.0		23.6	22.6
1940					25.9	28.9		22.0	24.0
1960					27.3	32.5		24.9	28.1
1978	31.9	28.8	34.9	32.2	29.1	35.2	29.6	26.5	32.7
Increase 1900–78:									
Years					4.9	9.7		6.4	11.3
Percent					20.2	38.0		31.8	52.8
At age 65:									
1900					11.5	12.2		10.4	11.4
1920					12.2	12.8		12.1	12.4
1940					12.1	13.6		12.2	14.0
1960					13.0	15.9		12.8	15.1
1978	16.3	14.0	18.4	16.4	14.0	18.4	16.1	14.1	18.0
Increase 1900–78:									
Years					2.5	6.2		3.7	6.6
Percent					21.7	50.8		35.6	57.9
At age 75:									
1900					6.8	7.3		6.6	7.9
1920					7.3	7.6		7.6	8.4
1940					7.2	7.9		8.1	9.8
1960					7.9	9.3		8.9	10.1
1978	10.4	8.7	11.5	10.3	8.6	11.5	11.2	9.8	12.5
Increase 1900–78:									
Years					1.8	4.2		3.2	4.6
Percent					26.5	57.5		48.5	58.2
At age 85:									
1900					3.8	4.1		4.0	5.1
1920					4.1	4.2		4.5	5.2
1940					4.0	4.3		5.1	6.4
1960					4.3	4.7		5.1	5.4
1978	6.4	5.5	6.9	6.2	5.3	6.7	9.0	7.8	9.9
Increase 1900–78:									
Years					1.5	2.6		3.8	4.8
Percent					39.5	63.4		95.0	94.1

PERCENT OF BABIES BORN IN 1900 AND IN 1978 EXPECTED TO SURVIVE TO SELECTED AGES

Age and year	Total			White			Other		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
To age 20:									
1900					76.4	79.0		56.7	59.1
1978	97.5	97.1	98.0	97.7	97.3	98.2	96.6	96.1	97.2
Ratio 1978/1900					1.3	1.2		1.7	1.6
To age 45:									
1900					61.4	64.7		39.2	42.3
1978	93.3	91.3	95.3	94.0	92.2	95.8	89.0	85.3	92.4
Ratio 1978/1900					1.5	1.5		2.2	2.2
To age 65:									
1900					39.2	43.8		19.0	22.0
1978	75.9	69.3	82.6	77.5	71.0	83.9	65.0	56.4	73.4
Ratio 1978/1900					1.8	1.9		3.0	3.3
To age 75:									
1900					21.4	25.4		8.9	11.1
1978	55.4	44.7	66.1	57.0	46.2	67.8	44.0	34.4	53.9
Ratio 1978/1900					2.2	2.7		3.9	4.9
To age 85:									
1900					5.3	7.1		2.0	3.6
1978	25.9	16.5	35.5	26.6	16.8	36.6	20.5	13.8	27.9
Ratio 1978/1900					3.2	5.2		6.9	7.8

LIFE EXPECTANCY AT BIRTH, SELECTED COUNTRIES

[1977 United Nations Demographic Yearbook]

Rank	Males			Females			Rank
	Country	Date	Years	Country	Date	Years	
1	Japan	1976	72.15	Norway	1975–76	78.12	1
2	Sweden	1972–76	72.10	Sweden	1972–76	77.75	2
3	Norway	1975–76	71.85	Japan	1976	77.35	3
4	Netherlands	1971–75	71.2	Netherlands	1971–75	77.2	4
5	Denmark	1975–76	71.1	France	1974	76.9	5
6	Israel	1975	70.3	Denmark	1975–76	76.8	6
7	Switzerland	1968–73	70.29	United States	1975	76.5	7
8	Spain	1970	69.69	Canada	1970–72	76.36	8
9	England and Wales	1974–76	69.62	Switzerland	1968–73	76.22	9
10	Canada	1970–72	69.34	Finland	1975	75.93	10
11	France	1974	69.0	England and Wales	1974–76	75.82	11
12	Italy	1970–72	68.97	Austria	1976	75.05	12
13	Germany, Democratic Republic	1969–70	68.85	Spain	1970	74.96	13
14	Ireland	1970–72	68.77	Italy	1970–72	74.88	14
15	United States	1975	68.7	Germany, Federal Republic	1974–76	74.81	15
16	Bulgaria	1969–71	68.58	New Zealand	1970–72	74.60	16
17	New Zealand	1970–72	68.55	Poland	1976	74.55	17
18	Cuba	1970	68.5	Belgium	1968–72	74.21	18
19	Germany, Federal Republic	1974–76	68.30	Germany, Democratic Republic.	1969–70	74.19	19
20	Austria	1976	68.07	Australia	1965–67	74.15	20
21	Belgium	1968–72	67.79	U.S.S.R	1971–72	74.0	21
22	Australia	1965–67	67.63	Israel	1975	73.9	22
23	Greece	1960–62	67.46	Bulgaria	1969–71	73.86	23
24	Finland	1975	67.38	Czechoslovakia	1977	73.6	24
25	Romania	1974–76	67.37	Ireland	1970–72	73.52	25

SEX RATIOS

As a result of the yet unexplained longer (and increasing) life expectancy for females as compared to males, most older persons are women—14.8 million women and 10 million men in mid-1980. Death rates are higher for males than for females at every age (including the fetus) so that although there are approximately 105 boy babies born for every 100 girl babies, the numbers at the same age even out by the end of the teens and then females outnumber males in ever larger numbers thereafter.

For the total 65-plus population, there are 147 women per 100 men. In the 65–74 age group, the ratio is 131, rising to 178 women per 100 men for those 75 and over. For the 85-plus group, there are 224 women per 100 men.[12] (See "Marital Status" and "Projections" below.)

MARITAL STATUS

In 1979, most older men were married (7.4 million or 77 percent) but most older women were widows (7.1 million or 52 percent). There are 5.3 times as many older widows as there are widowers. Among the 75-plus women, almost 70 percent were widows. About 35 percent of the married 65-plus men have under-65 wives.

MARITAL STATUS, BY SEX AND AGE GROUP, 1979

Sex and marital status	Numbers (thousands)				Percent distribution			
	45–54	55–64	65–74	75+	45–54	55–64	65–74	75+
Male: Total	11,036	9,744	6,385	3,163	100.0	100.0	100.0	100.0
Married	9,447	8,449	5,188	2,178	85.6	86.7	81.3	68.9
Not married	1,589	1,295	1,197	985	14.4	13.3	18.7	31.1
Single[1]	761	510	358	154	6.9	5.2	5.6	4.9
Widowed	194	328	591	759	1.8	3.4	9.2	24.0
Divorced	633	458	248	71	5.7	4.7	3.9	2.2
Female: Total	11,790	10,887	8,382	5,245	100.0	100.0	100.0	100.0
Married	9,402	7,629	4,090	1,150	79.7	70.1	48.8	21.9
Not married	2,388	3,258	4,292	4,095	20.3	29.9	51.2	78.1
Single[1]	520	504	504	324	4.4	4.6	6.0	6.2
Widowed	895	2,045	3,454	3,656	7.6	18.8	41.2	69.7
Divorced	972	709	335	113	8.2	6.5	4.0	2.2
Ratio:[2] Total	107	112	131	166				
Married	100	90	79	53				
Not married	150	252	359	416				
Single[1]	68	99	141	210				
Widowed	461	623	584	482				
Divorced	154	155	135	159				

[1] Never married.
[2] Number of women per 100 men.

[12] Computed from estimates prepared by the Census Bureau based on the 1970 census enumeration and the monthly Current Population Surveys thereafter.

The impact of differential life expectancies by sex may be illustrated by a theoretic application of life expectancies in 1978 to an assumed 100 marriages in 1980 where all grooms are aged 25 and all brides are aged 20, as follows:

Year	Age		Number expected to reach this age		Widows	
	Husband	Wife	Husband	Wife	Number	Percent
1980	25	20	100	100	0	0
1985	30	25	99	100	1	1
1990	35	30	98	99	1	1
1995	40	35	97	99	2	2
2000	45	40	95	98	3	3
2005	50	45	92	97	5	5
2010	55	50	88	96	8	8
2015	60	55	81	93	12	13
2020	65	60	72	90	18	20
2025	70	65	61	84	23	27
2030	75	70	47	77	30	39
2035	80	75	31	67	36	53
2040	85	80	17	53	36	68
2045	90	85	?	36	?	?

Note: In order to illustrate an extreme case, it was assumed that the male deaths were all among the married men with a spouse present while all of the female deaths were among the already widowed.

In 1978, there were approximately 2.3 million marriages of persons of all ages. The rate (number per 1,000 in the specific group who are theoretically eligible to marry) was 53.3 for females and 64.9 for males. As can be seen in the table below, the 2.3 million marriages included 19,800 65-plus brides and 37,600 65-plus grooms. The marriage rate for older grooms was almost 7 times that of the older brides (13.2 versus 2), partly because there are fewer males in these age groups and partly because men usually marry women younger than themselves. Approximately three-quarters of the older brides and grooms were previously widowed.

MARRIAGES OF PERSONS AGED 65 AND OVER IN 1978[1]

Previous marital status	Brides		Grooms	
	Number	Rate	Number	Rate
All marriages	19.8	2.0	37.6	13.2
First marriages	1.1	1.0	1.9	2.5
Remarriages	18.7	2.1	35.7	16.8
Previously widowed	15.5	1.8	27.3	15.6
Previously divorced	3.2	6.4	8.4	20.8

[1] Numbers in thousands. Rate is number per 1,000 in the specific group who are theoretically eligible.

EDUCATIONAL ATTAINMENT

In 1979, about half of all older Americans had less than a 10th grade education; the median for the 25–64 age group was high school graduation. About 2.1 million or 9 percent of the older people were "functionally illiterate," having had no schooling or less than 5 years. At the other end of the scale, about 8 percent were college graduates. The increasing educational attainment of the older population (an increase of more than a year of schooling in the median since 1970) results from a classic example of a cohort effect rather than the aging process; in the past, each succeeding generation has been given the opportunity to receive more schooling than did its predecessor—as each cohort with more years of schooling reaches age 65 and the oldest cohort with less schooling dies off, the median increases.

LIVING ARRANGEMENTS

In 1979, more than 8 of every 10 older men but less than 6 of every 10 older women lived in family settings. The others lived alone or with nonrelatives except for the one in twenty who lived in an institution (a figure that jumps to one in five in the 85-plus age group).

About three-quarters of the older men lived in families that included the wife but only slightly more than a third of the older women lived in families that included the husband. Four of every 10 older women lived alone. More than three times as many older women lived alone or with nonrelatives than did older men.

PLACE OF RESIDENCE

In 1979, a smaller proportion of the older noninstitutionalized population lived in metropolitan areas than was true of the younger (63 versus 68 percent) but in a reversal of the previous pattern, more than half of the older people in metropolitan areas lived in the suburbs rather than the central city, primarily because of the shift in the larger metropolitan areas (over 1 million inhabitants). The preponderance of suburbanites among the under-65 population increased substantially so that 60 percent of the under-65 residents of metropolitan areas lived outside the central city.

Proportionately more older than younger people lived in nonmetropolitan areas with the largest concentrations in the smaller areas (containing no county with more than 2,500 inhabitants).

As may be seen from the summary table just below, the last column (Ratio) shows that the changes between 1970 and 1979 involve the growth of the older population in the metropolitan area suburbs ("the aging of the suburbs"), especially in the larger areas. Although the older population in the nonmetropolitan areas also increased, the major patterns remained approximately the same.

The above analysis is based on the total population (see first table after the summary, part A). Patterns for the white elderly and the black elderly are, however, fundamentally different and are analyzed separately in parts B and C. In essence, the analysis shows that blacks of all ages are more concentrated in metropolitan areas than are whites and that better than three-quarters of the older blacks in metropolitan areas live in the central city.

DISTRIBUTION OF POPULATION BY METROPOLITAN/NONMETROPOLITAN RESIDENCE, BY AGE GROUPS, 1970 AND 1979

Residential category	1970		1979		Index[1]		
	Under 65	65-plus	Under 65	65-plus	1970	1979	Ratio[2]
Total	100.0	100.0	100.0	100.0	100	100	100
Metropolitan areas	69.1	64.2	68.1	63.4	93	93	100
In central cities	31.1	34.5	27.8	30.5	111	110	99
Outside central cities	37.9	29.7	40.3	33.0	78	82	105
Metropolitan areas of:							
1,000,000-plus:							
In central cities	16.9	19.8	14.6	16.2	117	111	95
Outside central cities	23.1	18.1	24.0	19.8	78	83	106
Less than 1,000,000:							
In central cities	13.1	14.7	13.2	14.3	112	108	96
Outside central cities	14.8	11.5	16.3	13.2	78	81	104
Nonmetropolitan areas	30.9	35.8	31.9	36.6	116	115	99
In counties with no place of 2,500-plus	3.5	4.7	4.0	5.0	134	125	93
In counties with a place of 2,500 to 24,999	19.5	23.3	20.0	23.3	119	117	98
In counties with a place of 25,000-plus	7.9	7.8	7.9	8.4	99	106	107
In counties designated metropolitan since 1970	4.2	4.4	4.5	5.0	105	111	106

[1] Index equals proportion of 65-plus divided by proportion under 65 times 100.
[2] Ratio equals index for 1979 divided by index for 1970 times 100.

ANALYSIS OF POPULATION BY METROPOLITAN/NONMETROPOLITAN RESIDENCE, BY AGE GROUPS, 1970 AND 1979

Residential category	Number (in thousands)						Percent distribution						Percent change 1970 to 1979		
	Under 45		45–64		65-plus		1970			1979					
	1970	1979	1970	1979	1970	1979	Under 45	45 to 64	65-plus	Under 45	45 to 64	65-plus	Under 45	45 to 64	65-plus
PART A.—TOTAL															
Total	139,344	149,303	41,240	43,457	19,235	23,175	100.0	100.0	100.0	100.0	100.0	100.0	+7.2	+5.4	+20.5
Metropolitan areas	96,385	101,823	28,329	29,400	12,344	14,698	69.2	68.7	64.2	68.2	67.7	63.4	+5.6	+3.8	+19.1
In central cities	42,829	41,464	13,407	12,044	6,640	7,056	30.7	32.5	34.5	27.8	27.7	30.5	−3.2	−10.2	+6.3
Outside central cities	53.556	60,360	14,922	17,355	5,704	7,642	38.4	36.2	29.7	40.4	39.9	33.0	+12.7	+16.3	+34.0
Metropolitan areas of:															
1,000,000-plus:															
In central cities	22,954	21,712	7,552	6,373	3,816	3,742	16.5	18.3	19.8	14.5	14.7	16.2	−5.4	−15.6	−1.9
Outside central cities	32,393	35,699	9,289	10,601	3,484	4,589	23.2	22.5	18.1	23.9	24.4	19.8	+10.2	+14.1	+31.7
Less than 1,000,000:															
In central cities	17,874	19,753	5,855	5,671	2,825	3,313	12.8	14.2	14.7	13.2	13.1	14.3	+10.5	−3.1	+17.3
Outside central cities	21,163	24,660	5,633	6,754	2,220	3,054	15.2	13.7	11.5	16.5	15.5	13.2	+16.5	+19.9	+37.6
Nonmetropolitan areas	42,959	47,479	12,911	14,057	6,891	8,477	30.8	31.3	35.8	31.3	32.4	36.6	+10.5	+8.9	+23.0
In counties with no place of 2,500-plus	4,738	5,870	1,551	1,796	902	1,149	3.4	3.8	4.7	3.9	4.1	5.0	+23.9	+15.8	+27.4
In counties with a place of 2,500 to 24,999	26,993	29,784	8,253	8,824	4,479	5,393	19.4	20.0	23.3	20.0	20.3	23.3	+10.3	+6.9	+20.4
In counties with a place of 25,000-plus	11,226	11,825	3,108	3,436	1,511	1,936	8.0	7.5	7.8	7.9	7.9	8.4	+5.3	+10.6	+28.1
In counties designated metropolitan since 1970	5,856	6,717	1,664	2,016	843	1,167	4.2	4.0	4.4	4.5	4.6	5.0	+14.7	+21.2	+38.4
PART B.—WHITE															
Total	120,540	126,950	37,204	38,740	17,532	20,950	100.0	100.0	100.0	100.0	100.0	100.0	+5.3	+4.1	+19.5

Metropolitan areas	82,398	84,573	25,333	25,805	11,207	13,168	68.4	68.1	63.9	66.6	66.6	62.9	+2.6	+1.9	+17.5
In central cities	32,089	29,624	11,069	9,415	5,751	5,897	26.6	29.8	32.8	23.3	24.3	23.2	−7.7	−14.9	+2.5
Outside central cities	50,308	54,948	14,264	16,390	5,457	7,272	41.7	38.3	31.1	43.3	42.3	34.7	+9.2	+14.9	+33.3
Metropolitan areas of:															
1,000,000-plus:															
In central cities	15,759	14,006	5,997	4,669	3,251	2,994	13.1	16.1	18.5	11.0	12.1	14.3	−11.2	−22.1	−7.9
Outside central cities	30,461	32,337	8,905	9,970	3,348	4,388	25.3	23.9	19.1	25.5	25.7	21.0	+6.2	+12.0	+31.1
Less than 1,000,000:															
In central cities	16,331	15,619	5,072	4,746	2,500	2,902	13.6	13.6	14.3	12.3	12.3	13.9	−4.4	−6.4	+16.1
Outside central cities	19,848	22,611	5,359	6,420	2,108	2,884	16.5	14.4	12.0	17.8	16.6	13.8	+13.9	+19.8	+36.8
Nonmetropolitan areas	38,143	42,376	11,871	12,935	6,324	7,782	31.6	31.9	36.1	33.4	33.4	37.2	+11.1	+9.0	+23.1
In counties with no place of 2,500-plus	4,039	5,177	1,407	1,646	818	1,038	3.4	3.8	4.7	4.1	4.3	5.0	+28.2	+17.0	+26.9
In counties with a place of 2,500 to 24,999	23,846	26,653	7,565	8,150	4,095	4,987	19.8	20.3	23.4	21.0	21.0	23.8	+11.8	+7.7	+21.8
In counties with a place of 25,000-plus	10,258	10,546	2,898	3,139	1,411	1,757	8.5	7.8	8.1	8.3	8.1	8.4	+2.8	+8.3	+24.5
In counties designated metropolitan since 1970	5,337	6,014	1,559	1,851	789	1,054	4.4	4.2	4.5	4.7	4.8	5.0	+12.7	+18.7	+33.6
PART C.—BLACK															
Total	16,858	19,034	3,649	4,053	1,549	1,954	100.0	100.0	100.0	110.0	100.0	100.0	+12.9	+11.1	+26.1
Metropolitan areas	12,609	14,702	2,706	3,077	1,027	1,325	74.8	74.2	66.3	77.2	75.9	67.8	+16.6	+13.7	+29.0
In central cities	9,939	10,671	2,155	2,380	815	1,029	59.0	59.1	52.6	56.1	58.7	52.7	+7.4	+10.4	+26.3
Outside central cities	2,670	4,032	551	697	212	295	15.8	15.1	13.7	21.2	17.2	15.1	+51.0	+26.5	+39.2
Metropolitan areas of:															
1,000,000-plus:															
In central cities	6,699	6,904	1,446	1,533	519	665	39.7	39.6	33.5	36.3	37.8	34.0	+3.1	+6.0	+28.1
Outside central cities	1,608	2,541	326	463	117	163	9.5	8.9	7.6	13.4	11.4	8.3	+58.0	+42.0	+39.3
Less than 1,000,000:															
In central cities	3,241	3,767	708	847	296	364	19.2	19.4	19.1	19.8	20.9	18.6	+16.2	+19.6	+23.0
Outside central cities	1,062	1,491	226	234	95	133	6.3	6.2	6.1	7.8	5.8	6.8	+40.4	+3.5	+40.0
Nonmetropolitan areas	4,249	4,332	943	976	522	629	25.2	25.8	33.7	22.8	24.1	32.2	+2.0	+3.5	+28.5
In counties with no place of 2,500-plus	578	585	127	126	75	95	3.4	3.5	4.8	3.1	3.1	4.9	+1.2	−0.8	+26.7
In counties with a place of 2,500 to 24,999	2,828	2,672	631	593	357	369	16.8	17.3	23.1	14.0	14.6	18.9	−5.5	−6.0	+3.4
In counties with a place of 25,000-plus	844	1,074	184	257	90	166	5.0	5.0	5.8	5.6	6.3	8.5	+27.3	+39.7	+24.4
In counties designated metropolitan since 1970	496	623	98	156	53	111	2.9	2.7	3.4	3.3	3.9	5.7	+25.6	+59.2	+109.4

VOTER PARTICIPATION

In the 1976 Presidential election, older people made up 15 percent of the voting age population but cast 16 percent of the votes.[13] Some 62 percent of the older population voted, a much higher proportion than the under-35 group but somewhat lower than the 35–64 groups. A higher *proportion* of older men than older women voted, but the women voters still outnumbered the men. Voter participation falls off sharply after age 75.

In the 1978 congressional election, when, as usual, there is smaller total voter turnout, older people still made up 15 percent of the voting age population but cast 18 percent of the votes. Some 56 percent of the older population voted, a much higher proportion than the under-35 and about the same as the 35–64 group.

The two detailed tables below analyze registration and voting behavior in the 1980 Presidential election by age groups in the population. While the long-term trend toward lower turnouts for voting in both Presidential and congressional elections continued, the relative patterns by age group remained about the same. Highest percentage voting remains with the middle-aged population, followed by the 65–74 group, a falling off in the 75-plus, and a low turnout for the young adults. Whites voted in greater proportions than did the blacks who, in turn, voted in larger proportions than did the Hispanics. Persons aged 65-plus made up 15.4 percent of the voting-age population but cast 16.8 percent of the votes. Older men had better voting records than older women but the larger number of women still meant more female votes (8.7 million versus 7 million). Older whites voted in considerably greater proportions than did blacks or Hispanics. Data for other minorities is not available.

[13] Computed from data published by the Census Bureau as a result of a supplementary question on the November 1976, 1978, and 1980, Current Population Surveys.

REPORTED REGISTRATION AND VOTING, BY AGE GROUP, NOVEMBER 1980

[Civilian, noninstitutional population; numbers in thousands]

Status	18-plus		18–44		45–64		65-plus					
							Total		65–74		75-plus	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent
All races:												
Both sexes	157,085	100.0	89,423	100.0	43,569	100.0	24,094	100.0	15,324	100.0	8,770	100.0
Registered	105,035	66.9	54,039	60.4	33,029	75.8	17,968	74.6	11,835	77.2	6,133	69.9
Voted	93,066	59.2	47,183	52.8	30,205	69.3	15,677	65.1	10,622	69.3	5,055	57.6
Did not vote	11,969	7.6	6,856	7.7	2,824	6.5	2,290	9.5	1,213	7.9	1,077	12.3
Not registered [1]	52,050	33.1	35,384	39.6	10,541	24.2	6,125	25.4	3,488	22.8	2,637	30.1
Not U.S. citizen	6,343	4.0	4,420	4.9	1,345	3.1	580	2.4	340	2.2	240	2.7
Male	74,082	100.0	43,326	100.0	20,837	100.0	9,920	100.0	6,676	100.0	3,244	100.0
Registered	49,344	66.6	25,620	59.1	15,903	76.3	7,821	78.8	5,343	80.0	2,478	76.4
Voted	43,753	59.1	22,215	51.3	14,554	69.8	6,984	70.4	4,852	72.7	2,132	65.7
Did not vote	5,591	7.5	3,406	7.9	1,348	6.5	836	8.4	490	7.3	346	10.7
Not registered [1]	24,738	33.4	17,705	40.9	4,934	23.7	2,098	21.1	1,333	20.0	765	23.6
Not U.S. citizen	2,942	4.0	2,164	5.0	592	2.8	186	1.9	110	1.6	76	2.3
Female	83,003	100.0	46,097	100.0	22,732	100.0	14,174	100.0	8,648	100.0	5,526	100.0
Registered	55,691	67.1	28,418	61.6	17,126	75.3	10,147	71.6	6,493	75.1	3,654	66.1
Voted	49,312	59.4	24,967	54.2	15,651	68.9	8,694	61.3	5,770	66.7	2,924	52.9
Did not vote	6,378	7.7	3,449	7.5	1,475	6.5	1,454	10.3	723	8.4	731	13.2
Not registered [1]	27,312	32.9	17,678	38.3	5,606	24.7	4,027	28.4	2,155	24.9	1,872	33.9
Not U.S. citizen	3,402	4.1	2,255	4.9	752	3.3	394	2.8	230	2.7	164	3.0
White:												
Both sexes	137,676	100.0	77,225	100.0	38,703	100.0	21,748	100.0	13,789	100.0	7,959	100.0
Registered	94,112	68.4	47,898	62.0	29,808	77.0	16,406	75.4	10,755	78.0	5,651	71.0
Voted	83,855	60.9	42,143	54.6	27,365	70.7	14,347	66.0	9,669	70.1	4,678	58.8
Did not vote	10,257	7.5	5,756	7.5	2,443	6.3	2,058	9.5	1,085	7.9	973	12.2
Not registered [1]	43,564	31.6	29,327	38.0	8,895	23.0	5,343	24.6	3,034	22.0	2,309	29.0
Not U.S. citizen	4,762	3.5	3,260	4.2	1,038	2.7	463	2.1	263	1.9	200	2.5
Black:												
Both sexes	16,423	100.0	10,224	100.0	4,159	100.0	2,039	100.0	1,352	100.0	687	100.0
Registered	9,849	60.0	5,537	54.2	2,885	69.4	1,429	70.1	998	73.8	431	70.1
Voted	8,287	50.5	4,530	44.3	2,546	61.2	1,211	59.4	877	64.9	334	48.6
Did not vote	1,562	9.5	1,005	9.8	339	8.2	218	10.7	121	8.9	97	14.1
Not registered [1]	6,574	40.0	4,688	45.9	1,275	30.7	610	29.9	354	30.7	256	37.3
Not U.S. citizen	472	2.9	354	3.5	101	2.4	18	.9	12	.9	6	.9
Spanish origin: [2]												
Both sexes	8,210	100.0	5,874	100.0	1,798	100.0	538	100.0	349	100.0	189	100.0
Registered	2,984	36.3	1,837	31.3	910	50.6	237	44.1	160	45.8	77	40.7
Voted	2,453	29.9	1,488	25.3	768	42.7	198	36.8	141	40.4	57	30.2
Did not vote	531	6.5	348	5.9	143	8.0	40	7.4	20	5.7	20	10.6
Not registered [1]	5,226	63.7	4,037	68.7	888	49.4	301	55.9	189	54.2	112	59.3
Not U.S. citizen	2,645	32.2	1,987	33.8	489	27.2	168	31.2	115	33.0	53	28.0

[1] Spanish origin may be of any race.

[2] Includes "not known" and "unreported."

COMPARISON OF DISTRIBUTION OF POPULATION AND OF VOTERS, BY AGE GROUP, NOVEMBER 1980

[Civilian, noninstitutional population]

Status	18-plus		18–44		45–64		65-plus					
							Total		65–74		75-plus	
	Persons	Voters	Persons	Voters	Persons	Voters	Persons	Voters	Persons	Voters	Persons	Voters
All races, both sexes	100.0	100.0	56.9	50.7	27.7	32.5	15.4	16.8	9.8	11.4	5.6	5.4
Male	100.0	100.0	58.5	50.8	28.1	33.3	13.4	16.0	9.0	11.1	4.4	4.9
Female	100.0	100.0	55.5	50.6	27.4	31.7	17.1	17.7	10.4	11.7	6.7	6.0
White	100.0	100.0	56.1	50.3	28.1	32.6	15.8	17.1	10.0	11.5	5.8	5.6
Black	100.0	100.0	62.3	54.7	25.3	30.7	12.4	14.6	8.2	10.6	4.2	4.0
Spanish origin [1]	100.0	100.0	71.5	60.7	21.9	31.3	6.6	8.0	4.3	5.7	2.3	2.3
All races, both sexes	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Male	47.2	47.0	48.5	47.1	47.8	48.2	41.2	44.5	43.6	45.7	37.0	42.2
Female	52.8	52.0	51.5	52.9	52.2	51.8	58.8	55.5	56.4	54.3	63.0	57.8
White	87.6	90.1	86.4	89.3	88.8	90.6	90.3	91.5	90.0	91.0	90.8	92.5
Black	10.5	8.9	11.4	9.6	9.5	8.4	8.5	7.7	8.8	8.3	7.8	6.6
Spanish origin [1]	5.2	2.6	6.6	3.2	4.1	2.5	2.2	1.3	2.3	1.3	2.2	1.1

[1] Spanish origin may be of any race.

MOBILITY

There are two ways of examining the mobility of older persons. One, called "general mobility" by the Census Bureau, is based on a more geographic approach and measures movers (people who change residences) as to whether they moved across county, State, and regional lines. The other, called "detailed mobility" by the Census Bureau, is based on a type of residential area approach and measures movers in relation to residence in a central city or suburb of a metropolitan area or of a nonmetropolitan area.

General Mobility

In the March 1979 household survey, only 3.9 million or 17 percent of the 65-plus noninstitutionalized population reported that they had moved in the 4-year period since 1975 (compared with over 43 percent for the population aged 4 and over). Of the 3.9 million older movers in the 1975–79 period, 57 percent moved within the same county, 22 percent moved to another county in the same State, 6 percent moved to a contiguous State, and 15 percent moved to a noncontiguous State. Although differing in proportions, older movers followed a pattern quite similar to that of movers of all ages as shown in the table below.

GENERAL MOBILITY, BY AGE GROUPINGS, 1975/1979 [1]

[Numbers in thousands]

Region and residence in 1979 compared to region and residence in 1975	Age 4 to 64			Age 65-plus		
	Number	Percent	Percent	Number	Percent	Percent
Total in 1979	180,262	100.0	--------	23,175	100.0	--------
Same house (nonmovers)	99,437	55.2	--------	19,161	82.7	--------
Different house within United States (movers)	77,895	43.2	100.0	3,923	17.0	100.0
Same county	44,945	24.9	57.7	2,223	9.6	56.6
Different county	32,949	18.3	42.3	1,707	7.4	43.5
Same State	17,341	9.6	22.3	879	3.8	22.4
Different State	15,607	8.7	20.0	828	3.6	21.1
Contiguous	4,852	2.7	6.2	247	1.1	6.3
Noncontiguous	10,756	6.0	13.8	580	2.5	14.8
Northeast in 1975	3,044	1.7	3.9	214	.9	5.5
North Central in 1975	3,942	2.2	5.1	224	1.0	5.7
South in 1975	5,198	2.9	6.7	270	1.2	6.9
West in 1975	3,424	1.9	4.4	120	.5	3.1
Movers from abroad	2,931	1.6	--------	85	.4	--------

See footnote at end of table.

GENERAL MOBILITY, BY AGE GROUPINGS, 1975/1979—Continued

[Numbers in thousands]

Region and residence in 1979 compared to region and residence in 1975	Age 4 to 64			Age 65-plus		
	Number	Percent	Percent	Number	Percent	Percent
Northeast in 1979	40,638	100.0		5,598	100.0	
Same house (nonmovers)	26,285	64.7		4,865	86.9	
Different house within United States (movers)	13,795	34.0	100.0	720	12.9	100.0
Same county	8,780	21.6	63.7	452	8.1	62.8
Different county	5,015	12.3	36.4	268	4.8	37.2
Same State	2,962	7.3	21.5	166	3.0	23.1
Different State	2,053	5.0	14.9	102	1.8	14.2
Northeast in 1975	1,057	2.6	7.7	63	1.1	8.8
North Central in 1975	238	.6	1.7	6	.1	.8
South in 1975	593	1.5	4.3	28	.5	3.9
West in 1975	166	.4	1.2	5	.1	.7
Movers from abroad	559	1.4		13	.2	
North Central in 1979	47,780	100.0		6,141	100.0	
Same house (nonmovers)	27,128	56.8		5,181	84.4	
Different house within United States (movers)	20,181	42.2	100.0	956	15.6	100.0
Same county	12,234	25.6	60.6	609	9.9	63.7
Different county	7,947	16.6	39.4	347	5.7	36.3
Same State	4,798	10.0	23.8	237	3.9	24.8
Different State	3,151	6.6	15.6	109	1.8	11.4
Northeast in 1975	297	.6	1.5	7	.1	.7
North Central in 1975	1,387	2.9	6.9	42	.7	4.4
South in 1975	939	2.0	4.7	52	.9	5.4
West in 1975	527	1.1	2.6	8	.1	.8
Movers from abroad	471	1.0		4	.1	
South in 1979	58,334	100.0		7,560	100.0	
Same house (nonmovers)	31,086	53.3		6,251	82.7	
Different house within United States (movers)	26,315	45.1	100.0	1,295	17.1	100.0
Same county	14,258	24.4	54.2	625	8.3	48.3
Different county	12,057	20.7	45.8	670	8.9	51.7
Same State	5,922	10.2	22.5	264	3.5	20.4
Different State	6,136	10.5	23.3	405	5.4	31.3
Northeast in 1975	1,090	1.9	4.1	132	1.8	10.2
North Central in 1975	1,359	2.3	5.2	95	1.3	7.3
South in 1975	2,804	4.8	10.7	151	2.0	11.7
West in 1975	882	1.5	3.4	27	.4	2.1
Movers from abroad	933	1.6		14	.2	
West in 1979	33,509	100.0		3,877	100.0	
Same house (nonmovers)	14,938	44.6		2,864	73.9	
Different house within United States (movers)	17,603	52.5	100.0	959	24.7	100.0
Same county	9,674	28.9	55.0	536	13.8	55.9
Different county	7,929	23.7	45.0	423	10.9	44.1
Same State	3,661	10.9	20.8	211	5.4	22.0
Different State	4,268	12.7	24.2	212	5.5	22.1
Northeast in 1975	599	1.8	3.4	13	.3	1.4
North Central in 1975	959	2.9	5.5	80	2.1	8.3
South in 1975	862	2.6	4.9	39	1.0	4.1
West in 1975	1,850	5.5	10.5	79	2.0	8.2
Movers from abroad	967	2.9		54	1.4	

[1] Computed from data published by the Census Bureau, reporting replies in the March 1980 Current Population Survey comparing location of residence in 1979 and in 1975.

A special analysis of the regional pattern of interstate movers over the 4-year period 1975–79 (see table below) shows some degree of concentration of movement but very far from the stereotypic belief of a large flow to the "sunbelt." First of all, only 828,000 or 3.6 percent of the older noninstitutionalized population in 1979 reported an interstate move in the previous 4 years; this represents 21.1 percent of the movers.

Starting with residence in 1975, of the 215,000 who lived in the Northeast, about 30 percent moved to another State in the Northeast and over 60 percent moved to a State in the South. Of the 223,000 movers who lived in the North Central States in 1975, about 19 percent moved to another State in the same region, 43 percent moved to the South and 36 percent to the West. Of the 270,000 movers who lived in the South in 1975, 56 percent moved within the South, about 30 percent moved northwards, and some 14 percent moved West. Of the 119,000 who lived in a Western State in 1975, more than 66 percent moved within the West and 23 percent to a State in the South.

REGIONAL PATTERNS OF INTERSTATE MOVERS AGED 65-PLUS, 1975/1979

Residence in 1979	Residence in 1975				
	Total	Northeast	North Central	South	West
Total number (thousands)	828	215	223	270	119
Northeast	102	63	6	28	5
North Central	109	7	42	52	8
South	405	132	95	151	27
West	212	13	80	39	79
Total percent (1975)	100.0	100.0	100.0	100.0	100.0
Northeast	12.3	29.3	2.7	10.4	4.2
North Central	13.2	3.3	18.8	19.3	6.7
South	48.9	61.4	42.6	55.9	22.7
West	25.6	6.0	35.9	14.4	66.4
Total percent (1979)	100.0	26.0	26.9	32.6	14.4
Northeast	100.0	61.8	5.9	27.4	4.9
North Central	100.0	6.4	38.5	47.7	7.3
South	100.0	32.6	23.5	37.3	6.7
West	100.0	6.1	37.7	18.4	37.3

Detailed Mobility

In 1979, 19.2 million or about 83 percent of the noninstitutionalized older people reported that they lived in the same house as they did in 1975. A quarter were living within the central city of a metropolitan area, 27 percent were still living in a suburb, and about 31 percent were still in a nonmetropolitan area.

Of the 3.9 million movers (17 percent of the older population), 44 percent reported a move within the same metropolitan area—21.3 percent moved within the central city, 14.4 percent within the suburbs, and 8.3 percent moved between the central city and the suburbs (both directions).

Almost 16 percent of the movers moved from one metropolitan area to another, about a third moving from a suburb in one area to a suburb in the new area.

More than a quarter of the movers moved from one nonmetropolitan area to another nonmetropolitan area with the remaining 15 percent of the movers moving in a criss-cross pattern. (See table below.)

DETAILED MOBILITY, BY AGE GROUPINGS, 1975/1979

[Numbers in thousands]

Residence in 1979 compared to residence in 1975	Age 4 to 64			Age 65-plus		
	Number	Percent	Percent	Number	Percent	Percent
Total	180,262	100.0	(1)	23,175	100.0	(1)
Same house (nonmovers)	99,437	55.2	(1)	19,161	82.7	(1)
Central city of SMSA	25,997	14.4	(1)	5,792	25.0	(1)
Balance of SMSA	41,336	22.9	(1)	6,260	27.0	(1)
Outside SMSA	32,101	17.8	(1)	7,111	30.7	(1)
Different house within United States (movers)	77,895	43.2	100.0	3,929	17.0	100.0
Within same SMSA	36,067	20.0	46.3	1,724	7.4	43.9
Within central city	13,824	7.7	17.7	835	3.6	21.3
Within balance of SMSA	14,735	8.2	18.9	567	2.4	14.4
Central city to balance of SMSA	5,369	3.0	6.9	238	1.0	6.1
Balance of SMSA to central city	2,138	1.2	2.7	85	.4	2.2
Between SMSA's	12,180	6.8	15.6	623	2.7	15.9
Between central cities	2,832	1.6	3.6	132	.6	3.4
Between balances of SMSA's	4,384	2.4	5.6	219	.9	5.6
Central city to balance of SMSA	3,115	1.7	4.0	183	.8	4.7
Balance of SMSA to central city	1,850	1.0	2.4	89	.4	2.3
From outside SMSA to an SMSA	4,949	2.7	6.4	222	1.0	5.7
To central city	1,961	1.1	2.5	77	.3	2.0
To balance of SMSA	2,988	1.7	3.8	145	.6	3.7
From SMSA to outside SMSA	6,320	3.5	8.1	371	1.6	9.4
From central city	2,880	1.6	3.7	214	.9	5.4
From balance of SMSA	3,441	1.9	4.4	156	.7	4.0
Outside SMSA at both dates	18,377	10.2	23.6	990	4.3	25.2
Movers from abroad	2,931	1.6	(1)	85	.4	(1)
To central city of SMSA	1,311	.7	(1)	46	.2	(1)
To balance of SMSA	1,126	.6	(1)	30	.1	(1)
To outside SMSA	496	.3	(1)	7	(2)	(1)

[1] Not applicable.
[2] Less than 0.05 percent.

VETERANS

PROJECTED NUMBER OF ALL MALES AND OF VETERANS, AGED 65 AND OVER, 1980, 1990, 2000 [1]

[Numbers in thousands]

Age	1980			1990			2000		
	Males	Veterans		Males	Veterans		Males	Veterans	
		Number	Percent		Number	Percent		Number	Percent
65-plus	10,108	2,960	29.3	12,000	7,188	59.9	12,716	7,821	61.5
65 to 69	3,859	1,510	39.1	4,471	3,586	80.2	4,152	2,181	52.5
70 to 74	2,853	710	24.9	3,281	2,295	70.0	3,521	2,251	63.9
75 to 79	1,698	186	11.0	2,148	873	40.6	2,509	2,059	82.1
80 to 84	989	299	30.2	1,264	316	25.0	1,472	1,027	69.8
85-plus	709	255	36.0	836	118	14.1	1,062	303	28.5

[1] Based on data supplied by the Veterans Administration and the Health Care Financing Administration, and a special site visit survey of VA geriatric research, education, and clinical centers.

As may be seen from the above table, veterans are an increasingly large proportion of the older male population, reaching 60 percent within the next 10 years. Aware of this rapidly increasing responsibility, the Veterans Administration has initiated a large number of programs in domiciliary, home, and institutional care areas, as well as extensive research in both the biomedical and social/behavioral aspects of aging. Beginning in 1973, the Veterans Administration has established 10 geriatric research, education, and clinical centers (GRECC) scattered across the country from Massachusetts to California, providing both direct programs and support to the other VA programs and facilities.

In 1978, the Veterans Administration spent $1,053 billion in health care of the older veterans.

EMPLOYMENT

In 1900, the male labor force numbered 27,640,000. In the 45-64 age group, there were 4,958,000 men in the labor force out of a total male population in this age group of 5,465,000 or a labor force participation rate of 90.3. The 65-plus male population totaled 1,555,000 so the 987,000 in the labor force represented a rate of 63.1. In the female labor force of 4,999,000, there were 672,000 aged 45–64 in the labor force or 13.6 percent of the 4,935,000 women aged 45–64 in the population. In the 65-plus group, there were 127,000 in the labor force out of a population of 1,525,000 older women or a rate of 8.3.

Between 1900 and 1950, the male 45–64 labor force participation rate remained relatively constant while the 65-plus rate fell rapidly, especially after the onset of the depression of the 1930's and the passage of the Social Security Act. The 45–64 rate for women showed a steady increase as women entered the labor market but the 65-plus rate moved slowly between 8 and 10 percent.

The following table analyzes the trends since 1950 in some detail. The long-term trends for women continue as previously but for men the decrease in labor force participation has moved down to just below 60 years of age. This "early retirement" phenomena (which also showed up in the increase in the number of persons claiming social security payments prior to age 65, even at reduced benefit amounts) is probably a combination of persons under 65 voluntarily opting for early retirement (especially if they have other retirement income), of persons unable to find jobs in their later years (the so-called discouraged worker) and of persons who for health or physical reasons cannot continue to work.

CIVILIAN LABOR FORCE PARTICIPATION RATES, PERSONS AGED 45 AND OVER, BY AGE GROUP AND SEX, 1950–79 [1]

Sex and age group	1950	1955	1960	1965	1970	1975	1979
Men:							
10 yr:							
45 to 54	95.8	96.5	95.7	95.6	94.2	92.1	91.4
55 to 64	86.9	87.9	86.8	84.6	83.0	75.8	73.0
65-plus	45.8	39.6	33.1	27.9	26.8	21.7	20.0
5 yr:							
45 to 49	NA	97.1	96.6	96.1	95.3	94.1	93.4
50 to 54	NA	95.7	94.7	95.0	93.1	90.1	89.6
55 to 59	NA	92.5	91.6	90.2	89.5	84.4	82.2
60 to 64	NA	82.5	81.1	78.0	75.0	65.7	61.8
65-plus	45.8	39.6	33.1	27.9	26.8	21.7	20.0
Women:							
10 yr:							
45 to 54	37.9	43.8	49.8	50.9	54.4	54.6	58.4
55 to 64	27.0	32.5	37.2	41.4	43.0	41.0	41.9
65-plus	9.7	10.6	10.8	10.0	9.7	8.3	8.3
5 yr:							
45 to 49	NA	45.9	50.7	51.7	55.0	55.9	60.4
50 to 54	NA	41.5	48.7	50.1	53.8	53.3	56.5
55 to 59	NA	35.6	42.2	47.1	50.4	47.9	48.7
60 to 64	NA	29.0	31.4	34.0	36.1	33.3	33.9
65-plus	9.7	10.6	10.8	10.0	9.7	8.3	8.3

[1] From published and unpublished data supplied by the Department of Labor.

The following table presents a more detailed analysis of the labor force and the status of its components in the third quarter of 1980 by sex and 5-year age groupings. Noteworthy are the sharp decreases in labor force participation rates with increasing age, the increase in the proportion of employed workers in agriculture with advancing age, especially for men, and the decrease in unemployment rate (though not the duration of unemployment).

LABOR FORCE STATUS OF THE CIVILIAN NONINSTITUTIONAL POPULATION BY AGE GROUP AND SEX, JULY–SEPTEMBER 1980

[Numbers in thousands]

Status	16-plus	55–59	60–64	65–69	70–74	75-plus
Both sexes: Total	164,475	11,286	9,730	8,593	6,667	8,693
In labor force	105,948	7,220	4,512	1,800	774	426
Participation rate	64.4	64.0	46.4	20.9	11.6	4.9
Employed	97,986	6,970	4,384	1,736	750	419
Agriculture	3,708	283	268	158	99	70
Percent of employed	3.8	4.1	6.1	9.1	13.2	16.7
Nonagriculture	94,278	6,688	4,117	1,577	651	349
Unemployed	7,961	250	128	66	24	7
Rate	7.5	3.5	2.8	3.7	3.1	1.6
Not in labor force	58,527	4,065	5,218	6,793	5,893	8,267
Percent of total	35.6	36.0	53.6	79.1	88.4	95.1
Male: Total	77,853	5,373	4,550	3,824	2,821	3,217
In labor force	61,115	4,393	2,792	1,078	506	293
Participation rate	78.5	81.8	61.4	28.2	17.9	9.1
Employed	56,730	4,237	2,708	1,038	492	286
Agriculture	2,929	223	232	142	86	62
Percent of employed	5.2	5.3	8.6	13.7	17.5	21.7
Nonagriculture	53,801	4,014	2,475	896	405	224
Unemployed	4,385	156	84	40	14	7
Rate	7.2	3.6	3.0	3.7	2.8	2.5
Not in labor force	16,738	980	1,758	2,745	2,315	2,924
Percent of total	21.5	18.2	38.6	71.8	82.1	90.9
Female: Total	86,622	5,913	5,180	4,769	3,846	5,476
In labor force	44,832	2,827	1,720	722	268	133
Participation rate	51.8	47.8	33.2	15.1	7.0	2.4
Employed	41,256	2,733	1,677	698	258	133
Agriculture	770	59	35	16	13	8
Percent of employed	1.9	2.2	2.1	2.3	5.0	6.0
Nonagriculture	40,477	2,674	1,642	681	246	125
Unemployed	3,576	94	43	26	10	0
Rate	8.0	3.3	2.5	3.6	3.7	0
Not in labor force	41,790	3,085	3,460	4,048	3,578	5,343
Percent of total	48.2	52.2	66.8	84.9	93.0	97.9

The following table analyzes the employment and unemployment status in the third quarter of 1980 for older members of the labor force according to their full-time or part-time attachment to the labor force. Especially noteworthy is the very rapid increase in the proportion of part-time workers, both men and women, with advancing age.

FULL-TIME/PART-TIME STATUS OF THE CIVILIAN NONINSTITUTIONAL POPULATION BY AGE GROUP AND SEX, JULY–SEPTEMBER 1980

[Numbers in thousands]

Status	16-plus	55–59	60–64	65-plus
Both sexes:				
Full-time labor force	92,083	6,523	3,827	1,547
Employed	85,401	6,300	3,721	1,491
Full time	80,603	6,065	3,576	1,366
Part time (economic reasons)	4,798	235	145	125
Unemployed	6,682	222	105	56
Rate	7.3	3.4	2.7	3.6
Part-time labor force	13,865	698	685	1,453
Percent of total labor force	13.1	9.7	15.2	48.4
Employed part time	12,586	670	663	1,414
Percent of total employed	12.8	9.6	15.1	48.7
Unemployed	1,279	28	23	39
Rate	9.2	3.9	3.3	2.7
Percent of total unemployed	16.1	11.0	17.7	40.9
Male:				
Full-time labor force	56,891	4,248	2,537	1,062
Employed	53,014	4,098	2,466	1,024
Full time	50,620	3,989	2,393	954
Part time (economic reasons)	2,394	109	73	70
Unemployed	3,877	149	71	39
Rate	6.8	3.5	2.8	3.7
Part-time labor force	4,224	146	255	815
Percent of total labor force	6.9	3.3	9.1	43.4
Employed part time	3,716	138	241	794
Percent of total employed	6.6	3.3	8.9	43.7
Unemployed	508	7	13	22
Rate	12.0	5.0	5.2	2.7
Percent of total unemployed	11.6	4.7	15.7	36.1
Female:				
Full-time labor force	35,192	2,275	1,289	485
Employed	32,386	2,202	1,255	468
Full time	29,983	2,076	1,183	412
Part time (economic reasons)	2,403	126	72	56
Unemployed	2,805	74	34	17
Rate	8.0	3.2	2.6	3.6
Part-time labor force	9,640	552	431	637
Percent of total labor force	21.5	19.5	25.0	56.8
Employed part time	8,869	532	421	620
Percent of total employed	21.5	19.5	25.1	57.0
Unemployed	771	20	9	17
Rate	8.0	3.7	2.2	2.7
Percent of total unemployed	21.6	21.5	21.4	49.5

AUTOMOBILE OWNERSHIP

As is true for major household appliances, automobile ownership by older households is well below that of households with younger heads but part of the difference depends on income level rather than age, health, or choice. A 1974 survey showed that 62 percent of older households owned at least one car as compared with 86 percent for the younger.[14] There is, however, a strong relationship between income level and auto ownership at all ages so the lower income level of the older households accounts in part for the lower ownership rate. Other factors are also present.

PROJECTIONS

The "safest" Census Bureau projections of the size and composition of the population through 2050 are the so-called "Series II" projections, which are based on an ultimate cohort fertility rate of 2.1 (2.1 children per woman or eventual zero population growth), small improvements in life expectancy (including that for older persons), narrowing of the gap between whites and blacks, constant 400,000 net immigration, but no new major medical "cures" of chronic diseases.

[14] Basic data from the discontinued Census Bureau series on Consumer Buying Intentions.

These projections show a total population of 260.4 million by 2000 with 31.8 million or 12.2 percent aged 65-plus (11.2 percent in 1979). The number of 85-plus persons would almost double to 3.8 million and the ratio of 65-plus women to men would rise to 150 to 100 as compared with 146 to 100 in 1979.

POPULATION PROJECTIONS (SERIES II), TOTAL AND 65-PLUS, 1980–2050[1]

[Numbers in thousands]

Year	All ages	65-plus				
		Both sexes		Female		
		Number	Percent of all ages	Male	Number	Per 100 men
1980	222,159	24,927	11.2	10,108	14,819	147
1985	232,880	27,305	11.7	11,012	16,293	148
1990	243,513	29,824	12.3	11,999	17,824	149
1995	252,750	31,401	12.4	12,602	18,799	149
2000	260,378	31,822	12.2	12,717	19,105	150
2005	267,603	32,436	12.1	12,924	19,512	151
2010	275,335	34,837	12.7	13,978	20,858	149
2015	283,164	39,519	14.0	16,063	23,456	146
2020	290,115	45,102	15.6	18,468	26,634	144
2025	295,742	50,920	17.2	20,861	30,059	144
2030	300,349	55,024	18.3	22,399	32,624	146
2035	304,486	55,805	18.3	22,434	33,371	149
2040	308,400	54,925	17.8	21,816	33,108	152
2045	312,054	54,009	17.3	21,335	32,674	153
2050	315,622	55,494	17.6	22,055	33,439	152

[1] Computed from the latest Census Bureau population projections (by age, sex, and color) as published in the Current Population Reports series. Detailed tables are based on the series II projections which assumed a 2.1 or "zero population growth," fertility rate for the future. Dependency ratios (gross) computed by the author from the projections and from data from previous census enumerations.

If the present fertility rate of approximately 1.8 (children per woman) should continue at this low level rather than the 2.1 rate assumed above, the size of the total population would be smaller but the *proportion* of older people would be larger. The increasing number and proportion of older persons reflect both the impact of longer life expectancy and the movement of the post-World War II baby boom through the population pyramid. Projections based on lower fertility rates also show a much smaller rate of growth for the older population after 2030 when today's babies and youngsters start reaching age 65.

The above projections represent averages for the whole 65-plus age group as if it were a homogeneous mass. Important differences by sex and age group within the 65-plus population are as follows:

PROJECTED TRENDS WITHIN THE 65-PLUS AGE GROUP, 1976–2050

[Percent change]

Sex and age	1976–2000	2000–25	2025–50
Both sexes, 65-plus	+38.8	+60.0	+9.0
65 to 74	+22.8	+77.5	−6.7
75 to 84	+56.9	+41.1	+14.9
85-plus	+91.1	+32.4	+91.6
Male 65-plus	+35.8	+64.0	+5.7
65 to 74	+24.4	+79.1	−6.3
75 to 84	+55.0	+44.1	+13.5
85-plus	+68.8	+29.9	+92.9
Female 65-plus	+40.8	+57.3	+11.2
65 to 74	+21.6	+76.2	−7.1
75 to 84	+58.0	+39.4	+14.3
85-plus	+101.4	+33.4	+91.1

Thus, comparison of the approximately 25-year timespans shows continuing increase to 2000, very rapid growth from 2000 to 2025 as the postwar babies reach the later years, then a sharp deceleration as the current low birth rates are reflected in a smaller cohort reaching 65. Significantly, the usually more rapid growth in the number of older women is reversed in the 2000 to 2025 period. But of even greater significance is the fact that between now and 2000 the oldest part of the older population will grow most rapidly, then be reversed between 2000 and 2025 and return to the current trend after 2025 when all rates of growth will be much slower, especially in the "younger" aged.

Does the age shift in the population create insurmountable "burdens"? Computation of a gross dependency ratio based on the assumption that the young (under 18) and the old (65-plus) are dependent on the middle group, the so-called "productive age" population, tends to show a quite reasonable "burden" on the middle group under reasonable economic and labor force assumptions:

Year	Number aged under 18 per 100 aged 18–64	Number aged 65-plus per 100 aged 18–64	Total
1930	58.9	9.1	68.0
1940	48.9	11.0	59.9
1950	51.0	13.4	64.4
1960	65.1	16.8	81.9
1970	61.4	17.7	79.1
1980 [1]	45.8	18.4	64.2
1990 [1]	43.5	20.0	63.5
2000 [1]	43.2	19.9	63.1
2010 [1]	39.2	20.2	59.4
2020 [1]	41.2	26.0	67.2
2030 [1]	42.0	31.8	73.8
2040 [1]	41.2	30.6	71.8
2050 [1]	41.7	30.2	71.9

[1] Projections, series II.

Exhibit A

Recent State Trends in the Older Population, 1970–79 [15]

Between 1970 and 1979, the Nation's older population (65-plus) increased from 20 million to 24.7 million or from 9.8 percent to 11.2 percent of the total population. As has been true for most of the 20th century, the older population grew considerably faster in 1970–79 (23.5 percent) than did the under-65 population (6.3 percent). These national trends, however, represent the averaging out of a variety of different State trends. Details and analyses are presented below.

PROPORTION OF THE POPULATION AGED 65-PLUS

For the Nation as a whole (50 States and the District of Columbia), the proportion of the total population in the 65-plus group rose from 9.8 percent in 1970 to 11.2 percent in 1979. The proportion ranged from 2.6 percent in Alaska and 7.7 percent in Hawaii to 18.1 percent in Florida and 13.7 percent in Arkansas.

[15] Computed by the author from reports on the 1970 census enumeration and from Census Bureau estimates of the population by age and by State for 1979, published in the Current Population Reports series.

In Wyoming, the only State where the under-65 group grew faster than the 65-plus, the proportion of older persons actually dropped, from 9.1 percent in 1970 to 8.1 percent in 1979. In five States (Alaska, Colorado, Idaho, New Hampshire, and Utah), the increase in the proportion of the State's aged population was 0.5 percentage points or less in the 9-year period. The remaining States had larger gains.

SUMMARY: STATES BY PERCENT OF POPULATION AGED 65-PLUS, 1979

18.1	1	Florida.
13.3 to 14.2	1	Arkansas.
12.3 to 13.2	10	Iowa, Kansas, Maine, Massachusetts, Missouri, Nebraska, Oklahoma, Pennsylvania, Rhode Island, and South Dakota.
11.3 to 12.2	11	Arizona, Connecticut, Minnesota, Mississippi, New Jersey, New York, North Dakota, Oregon, Vermont, West Virginia, and Wisconsin.
11.2 [1]	3	Alabama, Kentucky, and Tennessee.
10.2 to 11.1	9	California, District of Columbia, Illinois, Indiana, Montana, New Hampshire, North Carolina, Ohio, and Washington.
9.2 to 10.1	9	Delaware, Georgia, Idaho, Louisiana, Maryland, Michigan, South Carolina Texas, and Virginia.
8.2 to 9.1	3	Colorado, Nevada, and New Mexico.
7.2 to 8.1	3	Hawaii, Utah, and Wyoming.
2.6	1	Alaska.
Total	51	

[1] National average.

DISTRIBUTION AMONG THE STATES

The older population tends to be distributed among the States in the same general pattern as the total population except that there is a slightly greater concentration of older persons in some of the larger States. In the analytical table by State rank order (see last table of this exhibit), at the points where the States in the total population column and the 65-plus population column match exactly, the percentages are as follows:

States	All ages		65-plus	
	Percent of United States	Cumulative	Percent of United States	Cumulative
California	10.3	10.3	9.4	9.4
New York	8.0	18.3	8.6	18.0
Texas, Pennsylvania, Illinois, Ohio, Michigan, Florida	29.6	47.9	31.1	49.1
New Jersey	3.3	51.2	3.4	52.5
Massachusetts	2.6	53.8	2.9	55.4
North Carolina, Indiana, Virginia, Georgia, Missouri, Wisconsin, Tennessee	16.1	69.9	15.5	70.9
Maryland, Minnesota, Louisiana, Washington, Alabama, Kentucky, Connecticut, South Carolina, Iowa, Oklahoma, Colorado, Oregon, Arizona, Mississippi, Kansas, Arkansas	22.7	92.6	22.3	93.2
West Virginia	.9	93.5	.9	94.1
Nebraska	.7	94.2	.8	94.9
Utah, New Mexico, Maine, Rhode Island	2.1	96.3	1.9	96.8
Hawaii, Idaho, New Hampshire, Montana, Nevada, South Dakota, North Dakota, District of Columbia	2.8	99.1	2.7	99.5
Delaware	.3	99.4	.2	99.7
Vermont	.2	99.6	.2	99.9
Wyoming	.2	99.8	.1	100.0
Alaska	.2	100.0		100.0

RESIDENT POPULATION AGED 65-PLUS, BY STATE, 1970 AND 1979

State	Number (in thousands)		Percent increase		Percent of all ages		State rank [2]					
							Number		Percent increase		Percent of all ages	
	1970 [1]	1979	1960–70	1970–79	1970	1979	1970	1979	1960–70	1970–79	1970	1979
Total, 51 States	19,972	24,658	21.1	23.5	9.8	11.2	(3)	(3)	(3)	(3)	(3)	(3)
Alabama	324	421	24.7	29.7	9.4	11.2	21	19	16	16	30	25
Alaska	7	10	27.9	54.2	2.3	2.6	51	51	11	6	51	51
Arizona	161	289	79.0	79.5	9.1	11.8	35	30	1	2	34	16
Arkansas	237	300	22.0	26.6	12.3	13.7	28	28	21	22	3	2
California	1,792	2,316	30.9	29.3	9.0	10.2	2	1	9	18	36	34
Colorado	187	239	18.8	27.8	8.5	8.6	33	33	24	20	38	47
Connecticut	288	356	19.1	24.0	9.5	11.4	26	26	23	26	27	21
Delaware	44	57	22.6	30.0	8.0	9.7	48	48	20	15	42	37
District of Columbia	70	73	2.4	3.2	9.3	11.1	41	45	51	51	32	28
Florida	985	1,603	78.2	62.7	14.5	18.1	7	3	2	3	1	1
Georgia	365	488	26.4	33.6	8.0	9.5	17	16	15	11	42	40
Hawaii	44	70	51.3	59.9	5.7	7.7	47	46	4	4	50	50
Idaho	67	91	16.3	34.4	9.5	10.0	44	41	29	10	27	36
Illinois	1,089	1,220	12.2	12.0	9.8	10.9	4	6	40	47	24	29
Indiana	492	570	10.8	16.0	9.5	10.6	12	13	45	40	27	32
Iowa	349	381	6.9	9.2	12.4	13.1	19	22	49	49	2	4
Kansas	265	301	10.8	13.6	11.8	12.7	27	27	45	44	7	8
Kentucky	336	393	15.1	17.1	10.4	11.2	20	21	35	38	21	26
Louisiana	305	379	27.0	24.1	8.4	9.4	23	24	12	25	39	41
Maine	114	135	7.6	18.6	11.5	12.3	36	36	48	32	9	11
Maryland	298	380	32.3	27.3	7.6	9.2	25	23	8	21	45	44
Massachusetts	633	711	11.3	12.3	11.1	12.3	10	10	43	46	10	12
Michigan	749	887	18.0	18.4	8.4	9.6	8	8	25	34	39	39
Minnesota	407	470	15.4	15.4	10.7	11.6	15	18	33	41	14	19
Mississippi	221	276	17.0	24.8	10.0	11.4	30	31	27	24	22	22

Missouri	558	635	11.4	13.7	11.9	13.0	11	11	42	43	6	6
Montana	68	83	5.1	21.1	9.9	10.6	43	43	50	29	23	33
Nebraska	183	204	11.8	11.6	12.3	13.0	34	35	41	48	3	7
Nevada	31	61	70.4	96.6	6.3	8.6	49	47	3	1	49	46
New Hampshire	78	98	15.8	25.9	10.6	11.1	39	40	31	23	19	27
New Jersey	694	843	24.4	21.6	9.7	11.5	9	9	17	27	25	20
New Mexico	70	109	37.7	54.8	6.9	8.8	42	38	5	5	48	45
New York	1,951	2,115	15.8	8.4	10.7	12.0	1	2	31	50	14	15
North Carolina	412	571	32.7	38.6	8.1	10.2	14	12	7	8	41	35
North Dakota	66	80	13.3	20.5	10.7	12.1	45	44	36	31	14	13
Ohio	993	1,142	11.2	15.0	9.3	10.6	5	7	44	42	32	30
Oklahoma	299	363	20.1	21.5	11.7	12.5	24	25	22	28	8	10
Oregon	226	294	23.5	30.3	10.8	11.6	29	29	19	14	13	18
Pennsylvania	1,267	1,491	12.7	17.7	10.7	12.7	3	4	37	37	14	9
Rhode Island	104	123	16.1	18.6	10.9	13.2	37	37	30	33	12	3
South Carolina	190	269	26.8	41.6	7.3	9.2	32	32	13	7	46	43
South Dakota	80	90	12.5	12.4	12.1	13.1	38	42	38	45	5	5
Tennessee	382	492	24.0	28.8	9.7	11.2	15	15	18	19	25	24
Texas	988	1,302	32.9	31.9	8.8	9.7	6	5	6	13	37	38
Utah	77	106	29.4	37.3	7.3	7.7	40	39	10	9	46	49
Vermont	47	56	8.6	17.9	10.6	11.3	46	49	47	36	19	23
Virginia	364	483	26.6	32.7	7.8	9.3	18	17	14	12	44	42
Washington	320	415	15.4	29.5	9.4	10.6	22	20	33	17	30	31
West Virginia	194	226	12.5	16.6	11.1	12.0	31	34	38	39	10	14
Wisconsin	471	556	17.4	18.1	10.7	11.8	13	14	26	35	14	17
Wyoming	30	36	16.6	20.6	9.1	8.1	50	50	28	30	34	48

[1] Corrected for errors in number of centenarians.
[2] States ranked in decreasing order; State with largest quantity is ranked 1.
[3] Not applicable.

Source: Based on published and unpublished data, Bureau of the Census.

RESIDENT POPULATION, TOTAL, ALL AGES, AND AGE 65-PLUS, STATES IN RANK NUMBER ORDER, 1979

Rank	Total, all ages: State	Number (thousands)	Percent: Distribution	Percent: Cumulative	65-plus: State	Number (thousands)	Percent: Distribution	Percent: Cumulative	Rank
1	California	22,694	10.3	10.3	California	2,316	9.4	9.4	1
2	New York	17,648	8.0	18.3	New York	2,115	8.6	18.0	2
3	Texas	13,380	6.1	24.4	Florida	1,603	6.5	24.5	3
4	Pennsylvania	11,731	5.3	29.7	Pennsylvania	1,491	6.1	30.6	4
5	Illinois	11,229	5.1	34.8	Texas	1,302	5.3	35.9	5
6	Ohio	10,731	4.9	39.7	Illinois	1,220	5.0	40.9	6
7	Michigan	9,207	4.2	43.9	Ohio	1,142	4.6	45.5	7
8	Florida	8,860	4.0	47.9	Michigan	887	3.6	49.1	8
9	New Jersey	7,332	3.3	51.2	New Jersey	843	3.4	52.5	9
10	Massachusetts	5,769	2.6	53.8	Massachusetts	711	2.9	55.4	10
11	North Carolina	5,606	2.6	56.4	Missouri	635	2.6	58.0	11
12	Indiana	5,400	2.5	58.9	North Carolina	571	2.3	60.3	12
13	Virginia	5,197	2.4	61.3	Indiana	570	2.3	62.6	13
14	Georgia	5,117	2.3	63.6	Wisconsin	556	2.3	64.9	14
15	Missouri	4,867	2.2	65.8	Tennessee	492	2.0	66.9	15
16	Wisconsin	4,720	2.1	67.9	Georgia	488	2.0	68.9	16
17	Tennessee	4,380	2.0	69.9	Virginia	483	2.0	70.9	17
18	Maryland	4,148	1.9	71.8	Minnesota	470	1.9	72.8	18
19	Minnesota	4,060	1.8	73.6	Alabama	421	1.7	74.5	19
20	Louisiana	4,018	1.8	75.4	Washington	415	1.7	76.2	20
21	Washington	3,926	1.8	77.2	Kentucky	393	1.6	77.8	21
22	Alabama	3,769	1.7	78.9	Iowa	381	1.5	79.3	22
23	Kentucky	3,527	1.6	80.5	Maryland	380	1.5	80.8	23
24	Connecticut	3,115	1.4	81.9	Louisiana	379	1.5	82.3	24
25	South Carclina	2,932	1.3	83.2	Oklahoma	363	1.5	83.8	25
26	Iowa	2,902	1.3	84.5	Connecticut	356	1.4	85.2	26
27	Oklahoma	2,892	1.3	85.8	Kansas	301	1.2	86.4	27
28	Colorado	2,772	1.3	87.1	Arkansas	300	1.2	87.6	28
29	Oregon	2,527	1.2	88.3	Oregon	294	1.2	88.8	29
30	Arizona	2,450	1.1	89.4	Arizona	289	1.2	90.0	30
31	Mississippi	2,429	1.1	90.5	Mississippi	276	1.1	91.1	31
32	Kansas	2,369	1.1	91.6	South Carolina	269	1.1	92.2	32
33	Arkansas	2,180	1.0	92.6	Colorado	239	1.0	93.2	33
34	West Virginia	1,878	.9	93.5	West Virginia	226	.9	94.1	34
35	Nebraska	1,574	.7	94.2	Nebraska	204	.8	94.9	35
36	Utah	1,367	.6	94.8	Maine	135	.6	95.5	36
37	New Mexico	1,241	.6	94.5	Rhode Island	123	.5	96.0	37
38	Maine	1,097	.5	95.9	New Mexico	109	.4	96.4	38
39	Rhode Island	929	.4	96.3	Utah	106	.4	96.8	39
40	Hawaii	915	.4	96.7	New Hampshire	98	.4	97.2	40
41	Idaho	905	.4	97.1	Idaho	91	.4	97.6	41
42	New Hampshire	887	.4	97.5	South Dakota	90	.4	98.0	42
43	Montana	786	.4	97.9	Montana	83	.3	98.3	43
44	Nevada	702	.3	98.2	North Dakota	80	.3	98.6	44
45	South Dakota	689	.3	98.5	District of Columbia	73	.3	98.9	45
46	North Dakcta	657	.3	98.8	Hawaii	70	.3	99.2	46
47	District of Columbia	656	.3	99.1	Nevada	61	.3	99.5	47
48	Delaware	582	.3	99.4	Delaware	57	.2	99.7	48
49	Vermont	493	.2	99.6	Vermont	56	.2	99.9	49
50	Wyoming	450	.2	99.8	Wyoming	36	.1	100.0	50
51	Alaska	406	.2	100.0	Alaska	10	-------	100.0	51

97TH CONGRESS 1st Session } SENATE { REPORT No. 97-62

PART 1
DEVELOPMENTS IN AGING: 1980

MAY 13 (Legislative Day APRIL 27), 1981—Ordered to be printed

Mr. HEINZ, from the Special Committee on Aging, submitted the following

REPORT

[Pursuant to S. Res. 353, 96th Cong.]

Chapter 1

ECONOMIC PERFORMANCE AND ELDERLY STATUS, 1980[1]

CHAPTER HIGHLIGHTS

Instability and volatility characterized the American economy during 1980. The year began with the conclusion of the longest period of sustained economic growth during peacetime in U.S. history. This peak in business activity was accompanied by the fastest rate of price advance in more than 30 years and record high interest rates. These developments imposed hardships on a considerable portion of the U.S. population.

I. U.S. ECONOMY PERFORMANCE DURING 1980

The 1980 recession was shorter and somewhat milder than expected. As the year began, many forecasters anticipated the downturn lasting through the end of 1980 with the unemployment rate rising to well above 8 percent of the labor force. Instead, real gross national product (GNP), the market value of all goods and services produced in the United States adjusted for price changes, declined in the only second quarter of the year and rose modestly in the other quarters. The un-

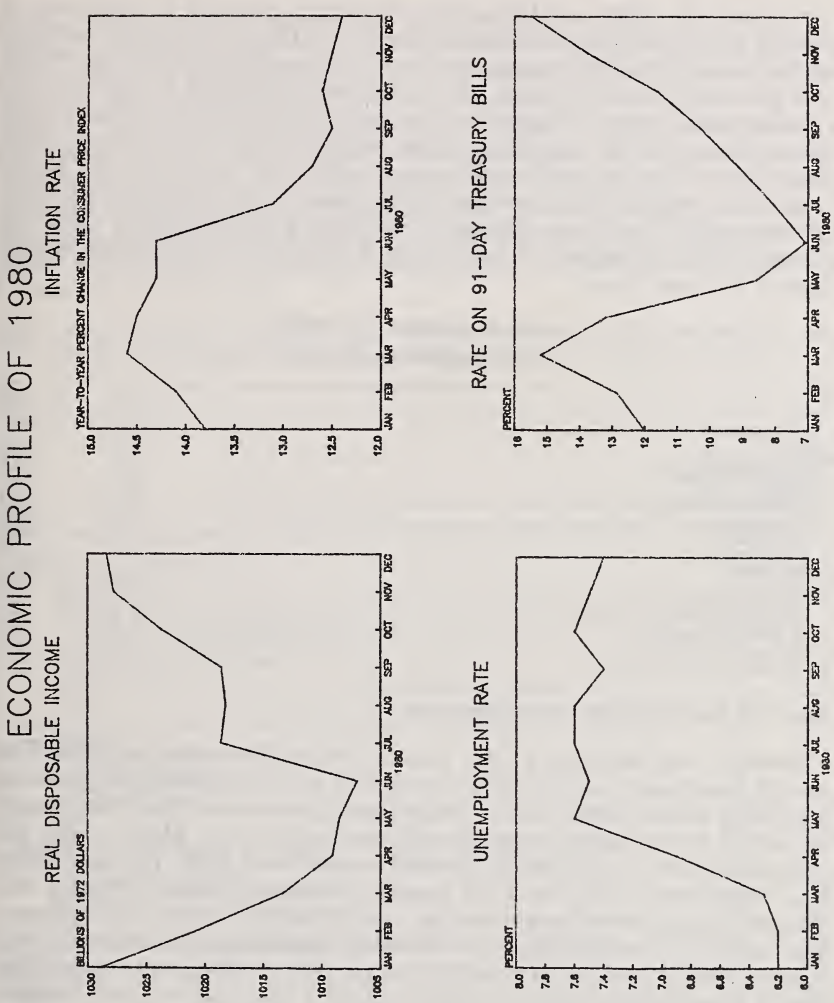
[1] Prepared by the Congressional Research Service, Library of Congress, by the following staff: Tom Gabe, analyst in social legislation, Education and Public Welfare Division; Barry Molefsky, analyst in econometrics, Economics Division; and Ray Schmitt, specialist in social legislation, Education and Public Welfare Division.

employment rate did not climb above 8 percent, and averaged about 7.5 percent in the last half of the year.

Over the past few years, policymakers and economists have tended to underestimate the vigor of the economy. The extent of this misjudgment became evident when the Commerce Department completed an extensive revision of the GNP and its components in December 1980. This revision reflected the availability of new data sources, such as the 1972 input-output tables and the 1977 censuses of business, as well as improved estimating procedures. The new figures show that the economy grew at an average annual rate of 3.3 percent between 1967 and 1979, significantly higher than the 3 percent rate previously reported. More than $60 billion (in 1972 prices) had been added to the level of real GNP. Much of this increase is due to higher estimates of business fixed investment and exports. Statistics on personal income were revised sharply upward as well. This new information suggests that productivity, investment, and savings during recent years were not as poor as previously thought. In addition, the economy was operating much closer to capacity than had been indicated, accounting for the inflationary pressures which confounded policymakers. In short, the economy has been healthier than believed.

Imbalances in the consumer sector and Federal monetary policies are widely believed to have been the major cause of the 1980 recession. Spurred by unusually large increases in prices during the 1975–79 expansion, consumer spending and borrowing advanced at an extremely rapid pace. In effect, households were substituting real assets (homes, automobiles, precious metals) for financial assets. Acquisition of these real assets was financed by borrowing. Consumer installment credit rose by 71 percent, between 1975 and 1979, as personal savings declined from 8.6 to 5.3 percent of after-tax income. The rise in debt also outpaced income gains; disposable personal income grew by just under 50 percent. In the 1980 Economic Report of the President, the Council of Economic Advisors warned:

> The ratio of consumer debt repayments to disposable income has risen steadily in recent years, reaching a record peak of 18 percent in the third quarter of 1979. The increase in this ratio has created concern that consumers are becoming overextended and has also raised fears that a high repayment burden might act as a strong constraint on consumer spending during an economic downturn.



The consumer sector did falter during the early months of 1980 in response to soaring interest rates and the imposition of credit controls. The second quarter slump was concentrated in credit sensitive sectors, particularly housing and motor vehicles. These two areas accounted for nearly two-thirds of the total decline in output. When the cost of money fell sharply between May and August 1980 and credit controls were lifted, the economy began to improve and continued to expand through the end of the year. By the end of 1980, economic indicators, such as industrial production, total employment, and real disposable income had nearly returned to prerecession levels.

Although the economy was in recession during 1980, inflation remained at extremely high levels. The Consumer Price Index (CPI), the most widely used and best known measure of inflation, increased about 13.5 percent compared with an 11.3 percent gain in 1979. Table

1 presents the 1979 and 1980 rates of gain in selected components of the CPI. It should be understood that the CPI is a weighted average of the prices of a representative bundle of goods and services. While it is possible that the prices of all the items included in that typical market basket may be rising at the same rate, it is more likely that some prices will be increasing more rapidly than the average, some prices more slowly, and some prices may even be declining. Moreover, these relationships are not stable; that is, the price of a particular commodity will not always be increasing more rapidly than the average. Price changes of individual items reflect the market conditions for those items.

TABLE 1—CONSUMER PRICE INDEX

[Percent change from previous year]

	1979	1980
All items	11.3	13.5
Food and beverages	10.8	8.5
Housing	12.2	15.7
Apparel and upkeep	4.4	7.1
Transportation	14.3	17.8
Medical care	9.3	10.9
Entertainment	6.7	8.9
Special indexes:		
Energy	25.2	30.9
All items less food	11.4	14.6
All items less mortgage interest	10.0	11.7
All items less medical care	11.4	13.6
All items less energy	10.0	11.6
All items less food and energy	9.7	12.9

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Energy and housing prices posted large advances in 1980. The energy component of the CPI [2] increased by a staggering 31 percent, primarily due to large rises in the price of imported oil and the phased decontrol of domestically produced crude oil prices. Most of the increases, however, occurred in the early months of 1980. Between June and November 1980, the CPI energy component was virtually unchanged and prices of some specific petroleum products, notably gasoline, actually declined in some months. Excluding the energy component, the all items CPI rose by 11.6 percent in 1980, indicating that nearly 2 percentage points of the total CPI increase was attributable to energy costs.

Sparked by substantial increases in the cost of homeownership, the housing component of the CPI rose by more than 15 percent last year. Over the course of 1980 the housing component fluctuated sharply, reflecting the volatility of mortgage interest rates. Contract mortgage interest costs, which includes interest rates and loan origination fees (points), rose nearly 35 percent in 1980.

The CPI is not the only available measure of price changes, another gage is the implicit price deflator for personal consumption expenditures, which some analysts believe is a more accurate yardstick than the CPI. In theory, these two price indexes are measuring the same

[2] This component includes only prices of direct consumer purchases of energy for the home and for motor vehicles.

thing, prices paid by consumers, and should increase at the same rate. Only rarely, however, do the two behave identically. For example, in 1980 the deflator rose by 10.2 percent, significantly lower than the CPI rise. This primarily reflects the different construction of the indexes. The CPI measures only changes in prices, while the consumption deflator measures changes in both prices and the composition of items purchased. A reconciliation of the rate of change in the CPI and the consumption deflator for the first and second quarters of 1980 is provided in the following table. The table shows the CPI rising much more rapidly than the deflator, mostly due to the differing treatment of homeownership costs.

TABLE 2.—RECONCILIATION OF PERCENT CHANGES IN THE IMPLICIT PRICE DEFLATOR FOR PERSONAL CONSUMPTION EXPENDITURES AND THE CONSUMER PRICE INDEX FOR ALL URBAN CONSUMERS

[Seasonally adjusted]

	1980	
	First quarter	Second quarter
Implicit price deflator for personal consumption expenditures (percent change at annual rate)	12.5	10.6
Less:		
Contribution of shifting weights in PCE	−.5	−.2
New autos	1.3	−4.3
Gasoline and oil	−.5	−.6
Electricity, gas, fuel oil, and coal	−1.0	.7
Furniture and household equipment	−.7	−.4
Food purchased for off-premise consumption	.6	1.3
Purchased meals and beverages	−.3	−.2
Clothing and shoes	−.4	1.0
Housing	.7	2.0
Other	−.3	.3
Contributions of differences in weights of comparable CPI and PCE expenditure components	−1.4	−.1
Gasoline and oil	−1.7	−.5
Electricity, gas, fuel oil, and coal	−.2	−.4
Household furnishings	.2	.2
Food at home and away from home	−.6	.1
Apparel commodities	.2	.1
Rent	−.3	−.3
Other	1.1	.8
Contributions of PCE expenditures components not comparable with CPI components	−1.0	−.5
New autos	−.1	0
Net purchases of used autos	−.1	−.3
Owner-occupied nonfarm and farm dwellings—space rent	−.9	−.3
Current expenditures by nonprofit institutions	.2	0
Other	−.1	0
Plus: Contribution of CPI expenditure components not comparable with PCE components	1.2	2.3
New autos	−.2	−.1
Used autos	−.3	−.8
Homeownership	2.1	3.6
Other	−.4	−.3
Less: Contribution of differences in seasonal adjustment	−.1	0
Equals: Consumer Price Index, all items (percent change at annual rate)	16.9	13.7

Source: Survey of Current Business, August 1980, p. 3.

Government economic policy during 1980 was aimed at reducing inflationary pressures rather than stimulating economic growth. Fiscal policy was relatively restrictive. The Federal budget deficit did balloon to $59.6 billion in fiscal year 1980, but this represents only 2.3 percent of nominal GNP, significantly lower than the percentage during the 1973–75 recession. Moreover, the rise in the deficit was mainly attributable to the automatic stabilizers in the budget (e.g., unemployment insurance benefits) rather than new antirecession spending programs. Unlike during some previous slumps, Federal tax liabilities were not reduced in order to stimulate economic activity.

Monetary policy played a major role in shaping economic developments during 1980. For some time the primary focus of the Federal Reserve has been to slow economic growth and thereby curb rising prices. In recent testimony before Congress, Paul Volcker, Chairman of the Board of Governors of the Federal Reserve System, described the current role of monetary policy. He stated:

> That role requires that the Federal Reserve apply the measured, persistent restraint on growth in money and credit that is necessary to drain the momentum from inflationary forces in the economy and to encourage a return to stability in prices and unit costs.

Preliminary statistics suggest that the Federal Reserve was unable to achieve "measured, persistent restraint" of money growth. Money growth was very uneven over the course of 1980. Between February and May, the narrowly defined money supply, M–1A, declined at an annual rate of 6.2 percent, and rose at a 12.5-percent annual rate between July and November. From the fourth quarter 1979 to the fourth quarter 1980, M–1A rose 5.1 percent, about the same rate of gain as during the preceeding four quarters. This increase was well within the target growth ranges established by the Federal Reserve Board. Growth of the more broadly defined monetary aggregates, however, was around the upper limit of the target ranges.

TABLE 3.—GROWTH IN MONETARY AND BANK CREDIT AGGREGATES

[Percent change]

Item	Actual		Federal Reserve target,
	1978 IV to 1979 IV	1979 IV to 1980 IV	1979 IV to 1980 IV
M–1A [1]	5.0	5.1	3½–6
M–1B [2]	7.7	7.4	4 –6½
M–2 [3]	9.0	9.9	6 –9
M–3 [4]	9.8	10.0	6½–9½
Bank credit [5]	12.3	7.9	6 –9

[1] M–1A is currency plus private demand deposits, net of deposits due to foreign commercial banks and official institutions.
[2] M–1B is M–1A plus other checkable deposits (negotiable order of withdrawal accounts, accounts subject to automatic transfer service, credit union share draft balances, and demand deposits at mutual savings banks).
[3] M–2 is M–1B plus overnight repurchase agreements (RP's) issued by commercial banks, overnight Eurodollar deposits held by U.S. nonbank residents at Caribbean branches of U.S. banks, money market mutual funds shares, and savings and small time deposits at all depository institutions.
[4] M–3 is M–2 plus large time deposits at all depository institutions and term RP's issued by commercial banks and savings and loan associations.
[5] Bank credit is total loans and investments plus loans sold at all commercial banks.

Source: Board of Governors of the Federal Reserve System.

II. INCOME OF THE AGED [3]

In 1978, the median income of families headed by persons age 65 and over was $10,124—a little over half that of families in which the head was less than 65 ($18,939). The median income of aged unrelated individuals (i.e., persons aged 65 and over living outside a family setting was $4,211, compared to $8,178 for nonaged unrelated individuals.

[3] Information about the income status of the aged reported in this section comes from the March 1979 Current Population Survey (CPS). Annual income information for 1979 will not be available until spring 1981.

The aged depend heavily upon income from sources other than earnings for their support. In 1978, 16 percent of aged unrelated individuals reported that they had income from earnings,[4] with half having earnings less than $2,505. In comparison, 85 percent of nonaged unrelated individuals reported that they had income from earnings, with half of them earning more than $8,991. Similarly, 48 percent of families with an aged head had income from earnings, compared to 94 percent of the families in which the head was less than 65; the median dollar amount earned was $6,700 and $8,310 respectively.

Social security was an important source of income for the aged. In 1978, slightly over 90 percent of the families with an aged head and aged unrelated individuals had income from this source.[5] The median amount received was $2,998 for aged unrelated individuals and $4,769 for families in which the head was 65 or older. While being an important source of income, social security was not usually the sole source of income for aged families and aged unrelated individuals. Only about 15 percent of aged unrelated individuals and 6 percent of the families with an aged head reported that social security was their sole source of income during the year.

Approximately one-quarter of aged unrelated individuals and two-fifths of the families with an aged head reported that they received income from private or Federal pensions during the year; the median amount received from these sources was $2,397 and $2,999 respectively.

About 12 percent of aged unrelated individuals and 8 percent of the families with aged heads received income from the supplemental security income (SSI) program. Of those receiving income from this source, the median annual payment reported by unrelated individuals was $1,052, and $1,227 for families in which the head was 65 years of age or older.

A large proportion of the aged had income from annuities, dividends, rents, and other periodic sources. Among aged unrelated individuals, 62 percent had income from these sources, with half of these receiving less than $825 over the course of the year. Approximately 70 percent of the families with an aged head had income from these sources, with half of these receiving less than $1,201.

In 1978, 13.9 percent of the approximately 23,175,000 persons age 65 and over had incomes less than the official poverty line.[6] The incidence of poverty was higher for the "very old" (age 85 and over) (19 percent) than for those who were between the ages of 65 and 74 (11.6 percent). The incidence of poverty was higher for aged families (16.7 percent) than for aged males (10 percent). The black aged had a poverty rate (33.9 percent) nearly three times higher than that of the white aged (12.1 percent). Aged persons living within a family setting had a lower incidence of poverty than aged unrelated individuals. About 7.6 percent of the aged who lived in families were poor, compared to 27 percent of those who lived outside a family setting.

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[4] Earnings refer to money wages and salaries, and net income from farm and nonfarm self-employment.

[5] Includes railroad retirement benefits.

[6] In 1978, the Census ("Orshansky") Poverty Index was $3,217 for a single person age 65 and over, and $3,944 for a couple in which the head was age 65 or over.

INCOME OF AGED AND NONAGED FAMILIES AND UNRELATED INDIVIDUALS, 1978

[By source and median dollar amount received]

Income source and median dollar amount	Families		Unrelated individuals	
	Head less than 65	Head age 65 and over	Less than 65	65 and over
Total	49, 293, 829	8, 510, 153	17, 253, 571	7, 610, 354
Median income	$18, 939	$10, 124	$8, 178	$4, 211
All sources	49, 029, 444	8, 492, 609	16, 516, 181	7, 588, 173
Percent of total	99. 5	99. 8	95. 7	99. 7
Median dollar amount received	$18, 978	$10, 148	$8, 632	$4, 218
Earnings [1]	46, 445, 765	4, 089, 751	14, 592, 822	1, 238, 430
Percent of total	94. 2	48. 1	84. 6	16. 3
Median dollar amount received	$18, 310	$6, 700	$8, 991	$2, 505
Sources other than earnings	37, 411, 209	8, 394, 182	10, 921, 474	7, 528, 522
Percent of total	75. 9	98. 6	63. 3	98. 9
Median dollar amount received	$1, 002	$7, 031	$560	$3, 926
Public assistance [2]	3, 271, 787	205, 314	408, 699	104, 910
Percent of total	6. 6	2. 4	2. 4	1. 4
Median dollar amount received	$2, 120	$1, 441	$1, 562	$443
Supplemental security income	910, 929	689, 718	419, 487	923, 388
Percent of total	1. 8	8. 1	2. 4	12. 1
Median dollar amount received	$1, 552	$1, 227	$1, 805	$1, 052
Social security, railroad retirement	5, 456, 836	7, 829, 884	1, 335, 173	7, 036, 975
Percent of total	11. 1	92. 0	7. 7	92. 5
Median dollar amount received	$3, 069	$4, 769	$2, 562	$2, 998
Private and Federal pensions	3, 012, 508	3, 325, 581	723, 325	1, 913, 547
Percent of total	6. 1	39. 1	4. 2	25. 1
Median dollar amount received	$4, 622	$2, 999	$2, 964	$2, 397
Veterans payments, unemployment compensation, workman's compensation	7, 301, 395	798, 391	1, 780, 090	600, 184
Percent of total	14. 8	9. 4	10. 3	7. 9
Median dollar amount received	$999	$1, 390	$933	$1, 078
All other sources [3]	30, 192, 286	5, 966, 521	8, 789, 249	4, 728, 111
Percent of total	61. 2	70. 1	50. 9	62. 1
Median dollar amount received	$300	$1, 201	$175	$825

[1] The sum of money wages or salary, and net income from farm and nonfarm self-employment.
[2] Public assistance payments such as aid to families with dependent children and general assistance. Separate payments received for hospital or other medical care (vendor payments) are excluded from this item.
[3] Includes: Annuities, alimony, regular contributions from persons not living in the family, and other periodic income.

Note: Table prepared by CRS. Figures are based upon the resident noninstitutionalized civilian population, and the noncivilian population who were not living in military barracks. Figures are subject to sampling error. Cell counts greater than 75,000 have approximately a 95-percent chance of being accurate within 20 percent. Cells with lower counts will have less accuracy.

Source: March 1979 Current Population Survey (CPS).

A. Social Security [7]

An automatic cost-of-living adjustment or "escalator" provision was added to the social security program in the Social Security Amendments of 1972, with the first automatic adjustment taking effect in July 1975. In each of the 6 years, 1975 through 1980, benefits have been automatically increased, since the Consumer Price Index (CPI) increased by at least 3 percent during the measuring period preceding each of these increases. An automatic increase is "triggered" for July of a given year if the CPI has increased by at least 3 percent from the first quarter of the previous year to the first quarter of the current year. Thus, there is, on average, a 10- to 11-month lag between the time the loss of purchasing power takes place and the time when benefits are correspondingly increased. Semiannual increases would reduce this lag time to 7 to 8 months, but would increase program costs by several billion dollars annually. Social security benefits were increased by 14.3 percent in July 1980 because the CPI increased by 14.3 percent between the first quarter of 1979 and the first quarter of 1980. Supple-

[7] This section was prepared by Nancy Miller, Income Maintenance Section, Education and Public Welfare Division.

mental security income (SSI) benefits paid to the elderly and the disabled are indexed in exactly the same way, and therefore those benefits also increased by 14.3 percent in June 1980.

Although the cost-of-living escalator continues to serve its original objective of preserving the purchasing power of social security benefits that would otherwise be eroded by inflation, the size of recent automatic increases has stimulated a great deal of comment and reevaluation of the automatic benefit increase provision as it operates in current law. Ironically, one of the reasons why an automatic benefit increase provision was introduced was in hopes that it would hold down the cost of the programs by eliminating the need for Congress to enact ad hoc increases from time to time—increases which were liable to exceed the actual increase in the CPI since the previous ad hoc adjustment. The 14.3-percent increase in July 1980 by itself added $17 billion to the cost of the social security programs.[8] Not only does this large increase have an effect on the overall Federal budget and on the financial status of the social security trust funds in particular, but it causes some diminished confidence in the system and resentment on the part of current workers, many of whose wages are not keeping pace with inflation. The benefit increase itself may be contributing to inflationary pressures.

Some have suggested that the Consumer Price Index for urban workers may not be the best measure for determining how large benefit increases should be. A number of studies have shown that the elderly have spending patterns systematically different from those of the urban worker population. Consumer Expenditure Survey data from the early 1970's suggest that families with a head of household over 65 spend more of their incomes on food, health care, fuel, and utilities, and less on housing, transportation, and clothing than families in general. Analysis done by the Bureau of Labor Statistics (BLS), however, suggests that an experimental CPI constructed specifically for the elderly would not have yielded results very different from the overall CPI during the years 1973–78. Interestingly, the BLS study showed the cost of living increasing at a slightly lower rate for the elderly than for the population at large, while a more recent study by Data Resources, Inc. (DRI), suggests that the cost of living increased at a slightly higher rate for consumers over 55 than for consumers under 55 during the 1970's. In other words, it is not clear that an alternative CPI constructed around the spending patterns typical of elderly persons would usually result in either higher or lower benefit increases for elderly social security beneficiaries. In addition, using a different price index for elderly and nonelderly beneficiaries might confuse the public and create additional opportunities for administrative error. Other population subgroups might seek special cost-of-living indexes tailored to their typical spending patterns, further complicating the issue.

The CPI now used to determine the amount of the annual benefit increase has also been criticized for overemphasizing the increase in the cost of housing as a component in the overall rise in the cost of living. The Carter budget just released recommends a new way of counting housing costs in the CPI, called a "rental equivalency"

[8] Office of the Actuary, Social Security Administration.

measure. Findings from studies to date, however, are so mixed that it simply is not clear that this alternative housing cost measure or any of the others that have been suggested is a better, or more accurate, measure of true cost or that it will result in a consistently higher or lower overall CPI.

B. Private Pensions

Pension benefits can be significantly affected by inflation both before as well as after retirement. While social security and Federal pension plans are indexed, private pensions generally do not provide automatic cost-of-living adjustments (COLA's) mainly because the costs of doing so are unpredictable and can be extremely high. Surveys show that only a small number of private pension plans have adopted automatic COLA's. Those that do usually have a 3-percent "cap" on any increase. Most pension plans do, however, extend pension increases to their retirees in a number of different ways. Almost always they are either collectively bargained for or else made available at the employer's initiative. These adjustments, however, do not keep pace with the rate of inflation.

Inflation has a relatively greater detrimental impact on a retiree who places greater reliance on a nonindexed or partially indexed pension to maintain a preretirement standard of living. Inflation, in turn, may cause greater reliance to be placed by present and future retirees on social security by lessening the role that pensions play in the overall retirement income scheme.

The combined effects of increases in longevity and early withdrawal from the labor force means a longer interval between the cessation of gainful employment and death. While a considerable number of workers retire early, the trend may be bottoming out. Whether the increase in the permissible mandatory retirement age from 65 to 70 under the 1978 Age Discrimination in Employment Amendments and the relatively high rates of inflation currently being experienced will reverse this trend remains to be seen. Surveys show that continued inflation is expected to have an effect on retirement decisions.

Work disincentives exist for continuing employment beyond age 65. Pension plans are not required to provide additional pension contributions or benefit accruals for service performed after age 65. Although a worker will be entitled to a higher social security benefit through delayed retirement credits, he or she might suffer an "opportunity cost" by not drawing social security benefits at age 65. The effect of these factors on a retirement decision is not clear. Given the prospects of continued double-digit inflation, however, the ability of individuals to maintain their preretirement standard of living will be seriously challenged.

Chapter 2

RETIREMENT INCOME

CHAPTER HIGHLIGHTS

The year 1980 ended and 1981 began with a sizable jump in the payroll tax. Wage earners will have to pay social security taxes on the first $29,700 of income in 1981, up from $25,900 in 1980. The tax rate increases from 6.13 to 6.65 percent for both employer and employees. For those earning over $29,700, the maximum tax paid will increase to a total of $1,975, or $387 more than last year (up 24 percent).

At the same time, retirees under social security will get a better break during 1981 on their outside earned income. Those aged 65 to 71 will be able to earn up to $5,500 instead of $5,000, the 1980 ceiling. Those under 65 will have a $4,080 ceiling on earnings, up from $3,720. Any earnings over these amounts are subject to an offset. For every $2 earned in excess of the limit, $1 in benefits is deducted.

In spite of these significant increases in the payroll tax, the social security system faces serious fiscal crises—both short term and long term.

Election year 1980 revealed an uneasy tension between retired voters dependent upon social security in a double-digit inflation economy, and an American public, whose economic mood had turned conservative, calling for major cutbacks in Government spending and a balanced budget. With social security outlays estimated to make up a substantial percentage of the total national budget, it is certain that efforts to cut spending and reduce deficits will include close scrutiny of the whole social security program.

I. SOCIAL SECURITY: MAJOR CHANGES AWAIT 1981

Although faced with forecasts of short-term cash flow problems and long-term deficits in the social security trust funds, Congress (with a few minor exceptions) avoided tackling these major financial crises. Nevertheless, 1980 proved valuable as a sounding board for possible new directions as several national commissions issued recommendations and the Committee on Aging closed the year with a series of hearings on "Social Security: What Changes Are Necessary?"

A. Short- and Long-Term Financing Issues

Despite 1977 Social Security Amendments designed to insure financial stability for several decades, reports by the Social Security Board of Trustees [1] have pointed to serious short- and long-term problems.

[1] The Secretaries of Health and Human Services, Labor, and the Treasury, serve as Trustees of the trust funds. The Commissioner of Social Security acts as secretary to the Trustees.

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The most recent report from the Trustees issued on June 17, 1980, forecast the following likely events using their "intermediate" assumptions:[2]

—The old-age survivors insurance (OASI) trust fund which pays retirement and survivor benefits will run into cash-flow difficulties in late 1981.

—In 1982, the OASI fund will be exhausted.

—From 1983 to 2010, OASI reserves will increase and then fall off again as the baby boom begins to retire.

—Sometime between 2020 and 2025, OASI funds will become exhausted again.

It is significant to note that early 1980 brought a level of high inflation reaching almost 18 percent. Coupled with rising unemployment, these economic developments only heightened trends that had been noticed earlier. In concluding their report, the Trustees made the following statement:

> The actuarial estimates presented in this report are based upon economic and demographic assumptions which are inevitably subject to considerable uncertainty. The assumptions and estimates that appear in this report were necessarily prepared before the most recent changes in the economy were known. Current evidence indicates that the economy has moved into a recession and is weakening rapidly. Therefore, revised short-range projections will probably be necessary in the near future as more information becomes available about the intensity of the changes in the economy. Over the longer term, uncertainty is, of course, an even more difficult factor. However, the Board believes that the long-range estimates presented in this report will remain useful for a longer period of time because they are less sensitive to changes in the short-range economic conditions.
>
> Over the short term the OASI trust fund will face financial strains requiring policy actions. Without such actions, the OASI fund would be depleted in late 1981 or early 1982, depending on the course of the economy. Reallocation of the

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[2] The payroll tax now provides income for three different trust funds administered by the Social Security Administration: The old-age survivors insurance trust fund (OASI) which is the largest and pays benefits to retirees and their survivors and dependents; the disability trust fund (DI) which pays disability benefits; and the health insurance trust fund (HI) which pays for medicare, part A, or hospitalization. The 1980–81 payroll tax rates were divided as follows among the three funds:

	OASI	DI	HI	Total
1980	4.52	0.56	1.05	6.13
1981	4.70	.65	1.30	6.65

This rate is paid both by the employer and the employee.

In making their projections, the Trustees cover the next 75 years for the OASI and DI trust funds. For the HI trust fund, they cover only the next 25 years.

These future cost estimates are prepared using three alternative sets of assumptions, referred to as "optimistic," "intermediate," and "pessimistic." Most important is the intermediate projection. For each set of assumptions, a different estimate is made for such important variables as mortality, fertility, net immigration, inflation, and others. Projections of this type made so long into the future have a lessening degree of certainty, yet they do furnish insight into later consequences of the existing program and possible changes.

tax rates between OASI and DI would postpone depletion until the latter half of 1982 or early 1983.

Following the year's early high inflation, trust fund news went from bad to worse. Each year the administration updates its budget projections in July. The administration's 1980 "midsession" forecast predicted that the OASI trust fund would be depleted in November 1981.

1. SOLUTIONS TO SHORT-TERM PROBLEMS

During the course of the year, several approaches surfaced to solve the short-term cash-flow problem spelled out by the Trustees. The major proposals were:

—*Reallocation:* Lower the percent of payroll tax going to the relatively solvent disability insurance (DI) trust fund and add it to the threatened OASI fund.

—*Interfund borrowing:* Instead of actually changing the rates of the three funds, permit a fund threatened by cash-flow difficulties to borrow from funds that are solvent, then reimburse later with interest.

—*Borrowing from the Treasury:* Rather than borrow from other funds, permit an endangered fund to borrow from general revenues and pay back the loan with interest after reserves have built up again.

—*Countercyclical financing from general revenues:* Permit the trust fund to use general revenues to make up losses when high unemployment reduces social security revenue.

—*Inject general revenues to pay all or part of the health insurance (HI) fund:* A major recommendation of the 1979 Advisory Council on Social Security, this proposal, by substituting general revenue funds for part or all of HI, would permit either the payroll tax to be reduced or the percent going to the OASI fund to be increased.

2. REALLOCATION AND H.R. 7670

Despite preoccupation with the elections, Congress did see its way clear to reallocate the payroll tax rates between the OASI and the DI funds for calendar years 1980 and 1981. Signed into law by President Carter on October 9, 1980, Public Law 96–403 (H.R. 7670) shifts income from the DI fund to the OASI fund. During 1980, OASI would get an additional 0.19 percent of the payroll tax and DI would get 0.19 percent less. The funds for 1980 could be transferred to OASI retroactively.

During 1981, OASI would get 0.175 percent more money and DI would get 0.175 less. Although this change in the law is largely technical in nature, its bottom-line effect is to "buy time" for Congress to consider more far-reaching legislative adjustments in 1981 to correct the short-term crisis.

The optimum reserve level for any trust fund is generally considered to be equal to 1 year's outlay of benefit payments. If one of the funds falls below an 8- or 9-percent reserve, a cash-flow problem exists. Checks must go out on the third of each month, but the tax comes in throughout the month. The reallocation of rates between OASI and

DI is estimated to insure a reserve of at least 12 percent in each fund through the end of 1981 as indicated in the following tables:

CASH BENEFITS SOCIAL SECURITY TAX RATES

[In percent]

Year	Old law			After H.R. 7670		
	OASI	DI	Total tax	OASI	DI	Total tax
Employer and employee, each:						
1980	4.33	0.75	5.08	4.52	0.56	5.08
1981	4.525	.825	5.35	4.70	.65	5.35
Self-employed persons:						
1980	6.01	1.04	7.05	6.2725	.7775	7.05
1981	6.7625	1.2375	8.00	7.025	.975	8.00

END-OF-YEAR CASH BENEFIT FUND BALANCES

[As a percent of following year outgo]

Year	Old law			After H.R. 7670		
	OASI	DI	Combined funds	OASI	DI	Combined funds
1980	15	44	18	18	20	18
1981	6	61	12	12	13	12

Note: Estimated by Social Security Administration actuaries.

Notwithstanding the passage of H.R. 7670, Congress must face up to additional changes in the law during 1981 if an impending cash-flow crisis is to be averted in 1982.

3. SOLUTIONS TO THE LONG-TERM DEFICIT

Although it seems almost certain that Congress will find solutions to the short-term cash-flow problem in 1981, it is not certain what action, if any, will be taken to relieve the much more serious long-term deficit facing the system in the 21st century.

The nature of this deficit is the result of several factors working together that suggest serious problems beginning as soon as the year 2010.

—*Increase in aged population:* The 1980 census will count some 25 million persons aged 65 and older, or roughly 11 percent of the population. By the year 2000, the Census Bureau predicts an increase to 32 million (or 13 percent). But when the baby boom (following World War II) reaches age 65, the impact will be even more dramatic. By the year 2030, it is estimated that the 65-plus age group will have grown to 50 million (or 22 percent).

—*Life expectancy:* Today, people are living, on the average, almost 3 years longer after age 65 than they did in 1940, when life expectancy at age 65 was 12 years for men and 13.6 years for women. Social Security Administration figures show that in 1975, life expectancy at age 65 increased to 13.6 years for men and 17.7 years for women, and by the year 2050, the years after 65 are expected to increase to 15.1 years for men and 19.7 years for women.

—*Labor force participation:* Recent years have indicated a growing trend toward earlier retirement by American workers. Between 1950 and 1979, the percentage of male workers remaining in the labor force after age 65 dropped from 39 to 20 percent. For male workers between the ages of 60 and 64 the average dropped from 79 percent (1950) to 62 percent (1979). The comparable rates for women increased between 1950 and 1970, but seemed to level off thereafter.[3]

Since social security is a pay-as-you-go system, with the benefits paid out each month funded by the payroll tax paid in by active workers, the ratio of workers to retirees takes on great significance. This ratio is commonly referred to as the dependency ratio. According to the intermediate assumptions of the Social Security Administration there are 31 beneficiaries for every 100 workers today—a ratio of roughly 3 recipients to every 1 worker. By the year 2030, that ratio may reach 2 to 1.

According to the 1980 Trustee's report mentioned above, under each set of their assumptions, the estimated payment of benefits (as a percent of taxable payroll) increases rapidly after the year 2000. Without changes in the program, these projections forecast severe financial difficulties in the next century.

Using intermediate assumptions, the OASDI trust fund balances would be exhausted by the year 2030; under the pessimistic assumptions, OASDI balances would be exhausted between the years 2010 and 2015. The following chart illustrates these predictions.

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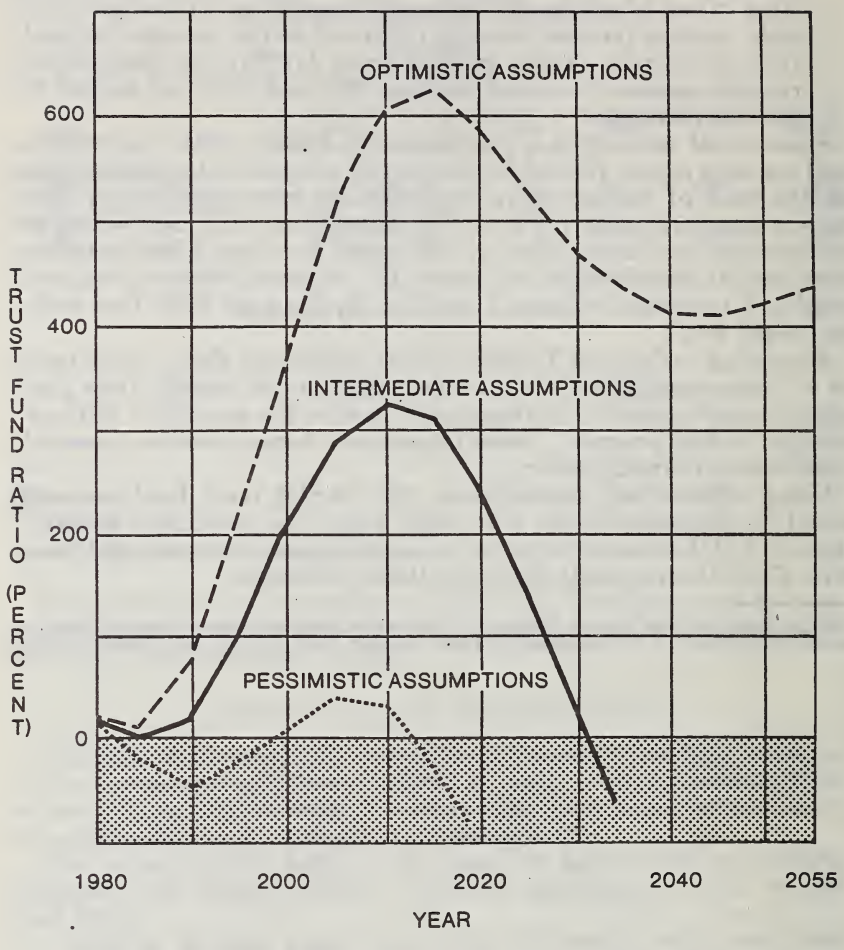
[3] U.S. Bureau of the Census. "Census of Population. Detailed Characteristics. Employment and Earnings." U.S. Department of Labor. January 1971, January 1979, January 1980.

OASDI TRUST FUND RATIOS PROJECTED 75 YEARS



Source: June 1980 OASDI Trustees' Report projections.

Unfortunately, there is no easy way to resolve the long-term deficit problem. Broadly speaking, the only options available are raising taxes, cutting benefits, or some combination of the two. Long-term solutions that have received the most attention in 1980 are listed below.

4. RAISE THE RETIREMENT AGE FOR FULL BENEFITS FROM 65 TO 68

Based partly on the reasoning that life expectancy after age 65 is rising, most versions of this proposal would phase in over 12 years a new eligibility age of 68 beginning after the year 2000. By making

the change now to phase in later, most workers would have at least 20 years to plan accordingly. Under this approach, the age of eligibility for reduced benefits would rise in a similar fashion from 62 to 65.

5. CAP OR ALTER THE PRESENT COST-OF-LIVING ADJUSTMENT BASED ON THE CONSUMER PRICE INDEX

The Secretary of Health and Human Services can increase the value of social security benefits each June whenever the cost of living as measured by the CPI has risen 3 percent or more between the first quarter of the previous year and the first quarter of the current year. In 1980, the increase was 14.3 percent. The impact on the national budget of this cost-of-living adjustment (or COLA) has become significant. It is now estimated that each increase of 1 percent in the COLA results in a cost to the budget of from $1 to $1.2 billion.

Several proposals to alter or limit this automatic COLA have been discussed including: (1) Cap the COLA at less than 100 percent of the rise in the CPI; (2) limit the increase to the rise in prices or wages whichever is lower; (3) alter the CPI to change the way in which the increase in the cost of housing is determined; [4] and (4) limit the COLA in years when the CPI has risen faster than wages and provide for retroactive "catchup" in future years when wages again rise faster than the CPI.

6. SWITCH FROM WAGE INDEXING TO PRICE INDEXING

In determining initial benefits to be awarded, a rather complicated formula is used. In applying this formula, average earnings of a worker are indexed, or adjusted, to reflect today's wages. Under present law, this adjustment is based on the increase in average wages.[5]

Because historically wages have grown faster than prices, price indexing would be less expensive and would result in significant long-term savings to the trust funds. One estimate states that since 1950, wages have grown at a rate of 330 percent, whereas prices have grown at only 218 percent.

While price indexing of initial benefits would lower expected benefits in the future, workers would still be guaranteed that their benefits would purchase the same level of goods as would the benefits of workers today with comparable wage records.

However, shifting to price indexing would, over the long run, substantially reduce the replacement rate (the proportion of a worker's recent earnings that are replaced by his social security benefit). For example, it is estimated that the replacement rate for the average

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[4] Many economists have argued that the CPI overstates the level of inflation because of how the costs of homeownership are measured. The combined cost of purchasing housing and financing this purchase make up almost 18 percent of the CPI. Because very few people purchase a home during any measurement period, it is argued that recent increases in home and mortgage interest costs do not accurately reflect true inflation for the vast majority who have not purchased homes during this period.

On the other hand, elderly households spend a larger percentage of income on necessities such as food, energy, and health care, the cost of which has been rising faster than the CPI. Therefore, in some ways, the CPI may understate the effect of inflation on elderly budgets.

[5] For more detailed discussion of the complicated issue, see the testimony of Robert J. Myers, "Social Security: What Changes Are Necessary?", hearings before the U.S. Senate Special Committee on Aging, Dec. 2, 1980.

worker retiring at age 65 will drop from about 41 percent today to 30 percent by 2010 and to 25 percent by 2050.

7. USE OF GENERAL REVENUE FUNDING

Similar to one of the short-term solutions discussed above, injecting general revenue funds into traditional social security programs could be designed to alleviate substantially the long-term deficit.

Former Commissioner of Social Security Robert M. Ball recommended such a plan, where one-half of the health insurance (HI) program would be funded by general revenues. At the same time he would keep the 1981 payroll tax rate constant at 6.65 percent, but would increase the combined OASDI portion from 5.35 to 6 percent. Under this approach, Ball predicts that additional tax increases now scheduled could be eliminated and the trust funds would be in good shape into the next century. The 6-percent rate for OASDI would quickly build up contingency reserves to reasonable levels. However, at some point after 2000, the OASDI rate would need to be raised to a rate of 7–7.5 percent to meet the costs now estimated by "intermediate" assumptions.[6]

B. Aging Committee Hearings—"Social Security: What Changes are Necessary?"

Anticipating the necessity for Congress to address social security financing issues in 1981, Committee Chairman Lawton Chiles and Ranking Minority Member Pete V. Domenici completed a series of four hearings in November and December 1980 entitled: "Social Security: What Changes Are Necessary?"

In announcing the hearings, Senator Chiles stated:

> Resolving the short- and long-range financing problems of social security must be a top priority for the 97th Congress. It is time to make the necessary hard decisions, and to restore full confidence in America's most popular and successful domestic program.

Joining Senator Chiles in stressing the urgency of the issues confronting the program, Senator Domenici added:

> I am particularly concerned that Congress and the American public be as well informed about these issues as possible. By structuring our hearings carefully, I believe the Committee on Aging is ideally suited to bring new information to light and to crystallize the differences between competing viewpoints.

1. INFORMATION PAPER SUMMARIZES RECENT RECOMMENDATIONS

As part of its effort to share as much information as possible on the emerging issues, the committee published a paper entitled: "Summary of Recommendations and Surveys on Social Security and Pension Policies." During 1979 and 1980, several reports and national surveys

[6] See testimony of Robert M. Ball, "Social Security: What Changes Are Necessary?", hearings before the U.S. Senate Special Committee on Aging, Nov. 21, 1980.

were released bearing directly on current issues in social security. These reports and surveys received much attention in the national press and stirred great interest in the American public, particularly with senior citizens and those nearing retirement.

The information paper summarizes the major recommendations and survey findings of these groups and condenses them into a single reference document. The reports summarized were:

—Report of the 1979 Advisory Council on Social Security.
—An Interim Report From the National Commission on Social Security.
—Report of the Universal Social Security Coverage Study Group.
—Social Security and the Changing Roles of Men and Women.
—1980 Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance (OASI) and Disability Insurance (DI) Trust Funds.
—An Interim Report From the President's Commission on Pension Policy.
—Preliminary Findings of a Nationwide Survey on Retirement Income Issues (Market Facts, Inc.).
—1979 Study of American Attitudes Toward Pensions and Retirement (Louis Harris & Associates).
—A Nationwide Survey of Attitudes Toward Social Security (Peter D. Hart Research Associates, Inc.).

2. SUMMARY OF HEARINGS

Not surprisingly, witnesses at the four hearings focused much of their testimony on possible solutions to the short-term cash-flow crisis and to the long-term deficit problem (see discussion of these issues above). In addition, the committee received up-to-date reports from many of the groups which have been created to study social security and related issues. Briefly summarized, the hearings highlighted the following testimony:

—*November 21, 1980:* A panel of national experts, including former Social Security Commissioner Robert M. Ball and Chairman of the 1979 Advisory Council on Social Security Henry Aaron, discussed solutions to the long-term deficit.
—*December 2, 1980:* Witnesses focused on possible changes in the cost-of-living adjustment and the proposed change from wage to price indexing in determining initial benefits. In addition, the effect of inflation on the elderly was discussed, and an update from the President's Commission on Pension Policy was presented.
—*December 3, 1980:* A panel of representatives from six national organizations representing a wide spectrum of constituencies of the elderly shared their views on many of the major proposals for revising the program that had been raised at the earlier hearings.
—*December 4, 1980:* Beginning with a panel representing national survey opinion firms sharing the results of their polls seeking American attitudes on social security issues, the hearings concluded with testimony from William J. Driver, Commissioner, Social Security Administration.

In addition to the four hearings held in Washington, which focused primarily on various aspects of social security, Senator Nancy Kassebaum chaired a hearing, on November 8, in Leavenworth, Kans., on the adequacy of retirement income from several benefit systems. This hearing, entitled "Retirement Benefits: Are They Fair and Are They Enough?", examined how inflation, demographic changes, and scarce resources will impact on social security, the railroad retirement system, the civil service retirement system, various military retirement programs, and tens of thousands of private pension plans across the country. The witnesses, who interacted with one another on a panel, included local representatives of retiree groups, State, and Federal officials.

C. Taxing Social Security Benefits

On December 7, 1979, the 1979 Advisory Council on Social Security released its report of recommendations covering many areas of social security. No recommendation caused more uproar in 1980 than the Council's suggestion that "half of social security benefits be included in taxable income for Federal income taxes." The fallout from this announcement, and its likely misinterpretation (some thought half their benefits were to be cut), was felt quickly on Capitol Hill.

An avalanche of letters and telegrams arrived in Washington attacking this immediately unpopular notion. In response, both the House and the Senate passed resolutions opposing the tax. S. Res. 432, passed by the Senate on August 4, 1980, and H. Con. Res. 351, passed by the House on July 21, 1980, expressed the sense of each House that the 96th Congress would not enact legislation changing the tax treatment of social security benefits.

The reasoning behind the Advisory Council's tax recommendation arguably made sense, despite its cold reception. Present tax treatment of social security was established not by law, but by rulings of the Bureau of Internal Revenue in 1941. As a result, social security benefits are not taxable today.

The Council felt that this treatment was wrong, that social security benefits should be treated to resemble more closely the way other pension income is treated. A recommendation to tax *half* the benefits was based on the grounds that the employee is already taxed on his contribution, but the other half is paid by his employer, and the worker is not taxed on that portion.

As measured by the Council, only a limited number of recipients would be affected by their recommendation:

> Because of the double income tax exemption for the elderly, almost no persons or couples over age 65 today would pay any additional income tax under the Council's proposal if social security were their only source of income. For example, if this provision were in effect in 1979, an aged couple would not be subject to any additional tax unless its total income, including the taxable half of its social security benefits, exceeded $7,400 per year. If the couple's only income were from social security, its benefits would have to exceed $14,800 before any tax would be payable. This is an amount higher than any couple retiring at age 65 in 1979 can receive.

Based on 1978 data, the Council estimated that taxing half of the benefits would affect 10.6 million tax-filing units (those with the highest taxable incomes) of the 24.2 million who received social security cash benefits. On average, the tax increase for these units would be $350 and the increase in Federal revenues would be $3.7 billion.

Based on the very negative reception this idea received from the public, its future legislative opportunities for action appear slim; however, one should note that the House and Senate resolutions passed in 1980 do not bind future Congresses.

D. The Earnings Limitation and H.R. 5295

Amendments to the Social Security Act passed in 1977 (Public Law 95–216) gradually liberalized the earnings limitation for social security beneficiaries and replaced the monthly earnings test with an annual test. Beginning January 1, 1981, beneficiaries over age 65 may now earn $5,500 before any reductions apply. Those under age 65 may earn up to $4,080. Any beneficiary earning over these amounts is subject to a reduction of $1 for every $2 earned over the limit.

Efforts by the 96th Congress to eliminate the earnings limitation altogether did not succeed; however, several changes to the earnings limitation were passed as part of H.R. 5295 (Public Law 96–473).

Prior to the 1977 amendments, the earnings limitation test was applied on a monthly basis. Regardless of annual income, a beneficiary could receive benefits as long as his or her monthly income did not exceed one-twelfth of the annual limit. The 1977 amendments removed the monthly test and replaced it with a stricter annual test, except for one "grace" year. Under the "grace" year exception, each person is entitled to apply the monthly test for the *first* year in which the individual has a month for which he or she is entitled to a social security benefit and where in that month, he or she earns less than one-twelfth of the annual exempt amount and does not perform substantial services in self-employment.

The elimination of the monthly retirement exception had a number of unanticipated results. Several classes of beneficiaries were inadvertently harmed by this change, and H.R. 5295 corrected these unintended effects:

—*People receiving child's benefits (including student's) and those under age 62 receiving mother's, father's, or wife's benefits:* The elimination of the monthly test had harsh results for those who moved in and out of the labor force. Benefits paid earlier in the year often became overpayments and had to be repaid from earnings later in the year. For this group, the monthly test is restored for the year (or each year) in which entitlement *ends* and is retroactive to January 1978.

—*People who had used their "grace" period before 1978:* Beneficiaries on the rolls before 1978 who had already used a "grace" year, were not entitled to another one. H.R. 5295 allows these people one year after 1978, and this provision is retroactive to 1978.

—*People whose application for medicare benefits unintentionally trigger the "grace" year:* Following the 1977 amendments, a per-

son who was not retiring, nevertheless had to file for cash benefits in order to establish eligibility for medicare hospital insurance. Thereafter, if this person had an isolated month with low or no earnings, his "grace" year would be triggered, and he would not be eligible later for using the monthly test when he actually retired. The new law allows people to have both hospital insurance protection and to reserve the "grace" year for the year of actual retirement.

—*People receiving income from self-employment based on services performed after entitlement:* Under prior law some self-employed persons (life insurance agents who receive renewal commissions after retirement, farmers whose leftover crops are sold after retirement, business partners who receive partnership income after retirement) lost benefits even though they did not work. The new law excludes from the earnings test self-employment income received after the year of entitlement that is not attributable to services performed after initial retirement.

E. Cost-of-Living Adjustments (COLA's) and the Challenges to the CPI

Since 1975, social security payments have been eligible for automatic cost-of-living adjustments in the first week of July. Increases are automatic whenever the Consumer Price Index (CPI) of the Bureau of Labor Statistics for the first calendar quarter of the current year exceeds the CPI for the first quarter of the previous year by at least 3 percent. The COLA for 1980 was 14.3 percent. The new benefit rates of July 1, 1980, resulting from this adjustment increased payments nationally by $1.3 billion per month for 35.3 million persons. When estimated new beneficiaries are added in, the estimated fiscal 1981 cost to the trust funds will be $16.8 billion. Viewed in another way, each 1 percent rise in the CPI results in an increase to the budget of almost $1.2 billion for social security benefits.

The 14.3-percent increase brought the following average monthly jump in benefits for beneficiaries:

	New average benefit per month	Increase
Retired worker:		
Men	$376.08	$47.11
Women	294.23	36.87
Disabled worker:		
Men	405.21	51.01
Women	296.00	37.22
Spouse of retired worker	170.30	21.34
Widow/widower not disabled	309.42	38.77

The average worker living alone (including men and women) now receives $330 per month (up $41). The average aged couple (both receiving benefits) receives $563 (up $70).

With social security COLA's resulting in budget increases of $16 billion and more, it was not surprising that this process and its measuring device, the CPI, were under close scrutiny by Congress and the

administration. However, early suggestions by the administration to "cap" the CPI increase at 85 percent (or lower) met stiff resistance.

The growing cost and importance of the social security COLA has raised several concerns: (1) Is it fair to give such large increases, 14.3 percent to nonworkers, when the comparable increase in wages (about 9.6 percent in 1980) is less for the workers whose taxes support the system? (2) Is the CPI the appropriate measure for adjusting benefits for inflation? (3) If the CPI is kept as the measuring device, should it be adjusted to reflect more accurately the true rate of inflation?

Many economists have argued that the CPI overstates the rate of inflation. How homeownership is measured lies at the center of this debate. For CPI purposes, the buying of a home and the costs of maintaining it are treated no differently than any other type of purchase. In fact, the price of a home and the cost of financing it make up almost 18 percent of the CPI. Critics of the CPI argue that most people do not purchase homes frequently. Therefore, the relative weight given to these costs distorts the inflation experience encountered by the typical consumer.

With a more conservative administration and Congress, it is almost certain that the issue of social security COLA's and the appropriateness of using the CPI will receive a great deal of attention in 1981.

F. President's Commission on Pension Policy: Interim Reports and Social Security

During 1980, the President's Commission on Pension Policy issued two interim reports which made several recommendations affecting social security. Created in 1978, the Commission is conducting a 2-year study of the Nation's retirement income policies.

The Commission's first interim report was released in May and included several tentative recommendations bearing directly on social security (see private pension section below for other recommendations). Perhaps central to their early analysis was concern over the development of a "two-class system of retirement in this country."

In announcing the first interim report, Commission Chairman C. Peter McColough (chief executive officer of Xerox Corp.) stated:

> One class of retirees does fairly well in retirement because they receive pension benefits from their employer, if he maintains a pension plan, and they also receive a social security check. The other class of retirees exists at or near the poverty line while relying almost exclusively on social security.

The May recommendations included the following:

—Contributions to and benefits from social security should receive the same tax treatment as do those of other retirement programs. This proposal would mean that income taxes on contributions to social security eventually would be deferred and benefits from social security would be counted as income subject to taxation.

—If the Commission recommendation on tax treatment of social security benefits is adopted, then the social security earnings test should be removed. The Commission staff was asked to study the cost implications of eliminating the test.

—After an appropriate transition period, the social security system should use an earnings sharing approach with at least some inheritance of a deceased spouse's credits by the survivor.

—The Commission expresses strong sentiment in favor of extending social security coverage to all new workers who otherwise would not be covered, but the staff is to present data showing the effects of alternatives to universal coverage that would remedy the windfall benefit and gap problem.

—The normal retirement age for social security should not be raised now out of recognition that there is a social contract with working people today who are approaching retirement age. However, the Commission has seriously considered whether the social contract with future generations of retirees should be changed and concludes that it is preferable to set the normal retirement age in terms of the proportion of adult life to be spent in retirement rather than in terms of an arbitrary age.

In their second interim report issued in November, the Commission repeated their concern over the "two-class" system of retirement and supported the principle that "a balanced program of social security, employee pensions, and individual savings should be available to all workers." Several disturbing facts were highlighted in the November report:

—In 1978, the average income of those age 65 and over receiving only social security was $5,556 for married couples and $2,688 for single persons.

—In 1978, the average total income for those with employee pensions was $10,000.

—Only 42 percent of all private sector workers are protected by pensions in their current jobs.

—A meager 23 percent of all private industry employees are actually eligible (vested) for pension benefits.

Major recommendations from the second report were:

—A normal retirement age of 68 should be phased in over a 12-year period beginning in the year 2000. This change should be adopted now to provide advance warning to younger workers that there will be a gradual move upwards.

—Social security benefits, once received, should continue to be fully adjusted to increases in prices. A separate price index for the elderly might be more appropriate. The Commission rejects indexing benefits by wages instead of the CPI, and it rejects only partial indexation (or capping).

The Commission rejected proposals to switch from wage indexing to price indexing in determining initial benefits; to change the current deferred retirement credit (now set at 1 percent and growing to 3 percent in 1982); and to separate explicitly the adequacy and equity functions of social security.

G. Report of Universal Social Security Coverage Study Group

Created by the 1977 amendments to the Social Security Act, the Universal Coverage Study Group was charged by law to examine the

feasibility and desirability of extending social security coverage to uncovered employees of Federal, State, and local governments and of nonprofit organizations.

Issued on March 24, 1980, the final report contained no specific recommendations, but it did provide a careful analysis of a variety of alternatives including their costs and benefits. Four major options were discussed in the report, and they are summarized below:

MANDATE COVERAGE

Social security coverage would significantly improve the protection provided to public employees and their dependents against income losses caused by disability or death. It would also guarantee that at least some percentage of anticipated retirement income would be fully portable from job to job throughout a career. In addition, many State and local government employees would benefit from higher adjustment of their pensions to compensate for cost-of-living increases when they are no longer working.

Against these advantages, many employees express concern that the relatively generous retirement income from their public retirement systems would be threatened by any proposed coordination with social security coverage. However, under options that are developed later in another part of the report, many employees would reap the benefits of mandatory coverage and would receive retirement income equal to or greater than the income they would have received under the current system.

Mandating social security coverage for all employment would resolve the windfalls and gaps issues most effectively. Initially, however, mandatory coverage on an incremental basis might be preferred. If so, several possibilities for coverage exist.

Coverage could be extended to all or only one of the major noncovered sectors, and directed toward only new employees or to all or some of the current workers within those sectors. Congress could choose to mandate coverage immediately for one group but to phase it in for the others.

Moreover, Congress could select different methods of mandating coverage for different groups. For example, Congress might extend coverage to Federal employment; both the Government and Federal workers would pay the payroll tax. In extending coverage to State and local employees, however, Congress might decide—either on the basis of constitutional implications or on the basis of one government's respect for another's jurisdiction—not to require State and local governments to pay the employer's share of the tax. Coverage could then be extended to these employees by treating their social security payments the way payments of self-employed individuals are treated. This might require a revision of the self-employment tax to prevent the creation of new inequities.

INCREASE INCENTIVES FOR VOLUNTARY COVERAGE

Another option is to establish more widespread coverage through voluntary participation. Pragmatically, this option is relevant only to State and local governments and to private, nonprofit organizations. If Congress approved coverage for Federal employees, directly implementing coverage would be more sensible than encouraging voluntary participation.

Voluntary coverage could be encouraged if social security revenues were raised by means other than, or in addition to, the payroll tax. General revenues, a value-added tax, and revenues from a "windfall profits tax" on oil companies have been suggested as potential sources of funds for the social security program. Because the burden of these other taxes would fall equally on covered and noncovered workers, incentives for voluntary participation would increase.

If these other sources of revenue were applied to the program, however, the effects would extend well beyond mandatory coverage issues. Assessing the desirability of the other effects was beyond the scope of the study group's charter.

Making revenue-sharing funds contingent on voluntary social security coverage would be one possible incentive approach. Revenue sharing now amounts to roughly 2 percent of State revenues. But social security coverage may increase total employer-employee retirement system costs by as much as 5 to 10 percent of State and local governments' payrolls. Because retirement systems are not always coterminous with units of government eligible to receive revenue-sharing funds, administering this incentive would be difficult.

Another approach would tie Federal grants-in-aid to social security coverage by requiring all employment subsidized by the grants to be covered. If social security coverage is in the national interest, justifying Federal subsidies of noncovered employment is difficult. The problem with this approach is that the ultimate effects might be felt not by State and local employees but by the persons the grant programs are designed to assist.

REDUCE GAPS AND UNDESIRABLE SUBSIDIES

A third option constitutes an entirely different approach. It would seek to reduce the problems without requiring coverage. Insurance gaps, windfalls, or both could be reduced without full coverage in several ways:

—A system for transfer of retirement credits could be established between social security and noncovered retirement systems. This action would help reduce coverage gaps for most individuals who leave noncovered employment.

—A minimum level of protection could be required by imposing mandatory minimum standards on noncovered retirement systems. This action would at least partially eliminate coverage gaps.

—The social security benefits of individuals with periods of noncovered employment could be adjusted to remove or reduce windfall benefits.
—The option to withdraw from social security currently available to State and local government employees could be eliminated. Although this action would not reduce the current gap or windfall problem, it would help prevent it from worsening.

MAINTAIN THE STATUS QUO

The final option is to do nothing, to maintain the status quo. The study group found no support for continuing the status quo in regard to windfalls, and no organization claimed that its members had a right to gain future windfalls. If there were no transitional costs associated with achieving an equitable distribution, maintaining the status quo would hardly be considered.[7]

H. Unemployment Compensation Offset to Pensions

On April 1, 1980, legislation went into effect that required all States to "offset," or reduce, any unemployment compensation benefits received by any person who is also receiving a government or private pension, including social security. The unemployment compensation benefit must be reduced dollar-for-dollar by the amount of the pension benefit.

In 1976, the 94th Congress, responding to reports of a variety of abuses of the unemployment insurance program during the 1973–74 recession, enacted legislation to correct such abuses (Public Law 94–566). One element of this legislation—an amendment to section 3304(a) of the Internal Revenue Code of 1954—was enacted to require that older workers who had retired from the labor force should not be eligible for unemployment compensation benefits in addition to their retirement benefits. However, later legislation (Public Law 95–19) delayed the effective date of the offset until April 1, 1980. The delay was at least in part designed to provide time for the National Unemployment Compensation Commission to study the issue and present its findings and recommendations to Congress.

As the effective date drew near, renewed opposition to the offset grew. The 1976 law had not considered carefully the retiree who must return to the labor force because his or her inflation-eroded pension is not sufficient to live on. After returning to work, the unretired worker typically earns new unemployment compensation rights. When this retired-but-working-again older person becomes unemployed, the argument can be made that he or she should not have the newly earned unemployment compensation reduced by some previously earned pension benefit.

In sum, many individuals earn rights to pension benefits from one job and rights to unemployment compensation from a second or later

[7] This analysis, taken directly from the report, was prepared by the Congressional Research Service as part of a "Summary of Recommendations and Surveys on Social Security and Pension Policies," an information paper by the U.S. Senate Special Committee on Aging, October 1980, pp. 29–31.

job. Consequently, in early 1980, both the House and the Senate passed bills which would have modified or eliminated the required offset, but differences between the two bills could not be resolved in time, and the 1976 legislation went into effect on April 1, 1980.

In July–August 1980, Senators Chaffee and Bradley proposed the already passed Senate version of the bill as an amendment to the pending ERISA multiemployer pension reform bill (S. 1076). Strong differences existed, however, between the House and Senate versions of the unemployment compensation amendment.

In fact, although the House and Senate were in virtual unanimity over the ERISA bill itself, disagreement over the unemployment compensation amendment threatened passage of the whole legislative package.

Finally, a compromise remedy to the offset was passed in September 1980, as part of the ERISA reform legislation (Public Law 96–364). The offset (or reduction) of unemployment benefits by the amount of any pension is now required in the United States only in those cases where the pension is established by the "base period employer"—that is, the employer responsible for the unemployment compensation benefit. The "base period" is typically defined by the States as the 12-month period that precedes the day the individual filed for the unemployment compensation.

In short, the States must continue to apply the offset if, in fact, the same "base period" employment would result in both a pension and an unemployment insurance benefit. If the post-retirement work for the same employer does not affect either the eligibility for, or the amount of, the pension, however, the States are not required to make the offset. Also, if the two benefits are not produced by the same "base employment," no offset is required.

The situation is more complex with respect to social security, since two different employers are each likely to have contributed to the same pension system, in this case social security. As a consequence, the new offset rules allow the States—if they choose—to reduce the required offset by an amount equal to any contributions the employee made toward the pension. In the case of social security, where employers and employees contribute equal amounts, States may limit the offset to one-half of the amount of a social security pension received by the individual who also qualifies for unemployment compensation benefits.

It should be noted that unemployment compensation is a State program and the new Federal legislation only requires the State to reduce the unemployment compensation by half of the social security benefit. The State may, however, reduce the unemployment by the entire amount of the social security benefit if it so decides.

I. Other Issues

1. Limitation on payment of retroactive social security benefits

Prior to passage of the Omnibus Budget Reconciliation Act of 1980 (Public Law 96–499), social security benefits could be paid retroactively for 12 months, if eligibility were determined. The Reconciliation Act reduced the retroactive provisions to a period of 6 months prior to

the month in which application for benefits is made. Benefit applications for disabled workers, their dependents and disabled widow(er)s, however will continue to be made retroactively for 12 months.

2. WITHDRAWAL FROM SOCIAL SECURITY COVERAGE

Faced with growing concern over the increasing number of terminations of participation in social security by State and local governments, the Committee on Aging published an information paper entitled: "State and Local Government Terminations of Social Security Coverage" (December 1980). Prepared with the assistance of the Social Security Administration, this paper updates an earlier study released by the committee in September 1976, entitled: "Social Security Coverage: The Impact on State and Local Government Employees." The new report provides an objective assessment of the arguments for and against social security, and it includes an analysis of the withdrawal of the State of Alaska from coverage, as well as a dollars and cents look at the value of social security.

In announcing the release of the paper, former committee Chairman Lawton Chiles stated:

> Anyone considering the option of terminating social security coverage should weigh the pros and cons very carefully. It is my hope that this paper will prove valuable to all those who are faced with this important decision.

II. PRIVATE PENSIONS

The most significant developments in the area of private pensions included efforts to strengthen multiemployer pension plans and the tentative recommendations of the President's Commission on Pension Policy.

A. ERISA and Multiemployer Pension Plan Termination Insurance

After long debate and many delays, Congress finally succeeded in passing legislation to tighten funding requirements and reduce government liability for 2,000 multiemployer pension plans covering 8 million workers.

In 1974, Congress enacted the Employee Retirement Income Security Act (ERISA). As part of this legislation, Congress created a self-insurance program to guarantee promised pension benefits for employees covered by single-employer and multiemployer plans. Multiemployer plans are pension plans which are the subject of collective bargaining between employers and unions and to which more than one employer contributes.

Workers in such industries as trucking, coal mining, retail food, construction, and entertainment are frequently covered by multiemployer pension plans under terms of their union contracts. Under ERISA, such plans may not defer funding or reduce benefits to retirees even if employment in their industries declines.

If employment does decline, both employers and employees must raise their premiums to continue funding benefits for workers who

have retired, or withdraw from the plans altogether. Because of economic and demographic developments since 1974, employers and active workers in some multiemployer plans are paying a very high price to maintain the often meager benefits of a growing number of retirees.

Because ERISA provided little incentive for companies to retain membership in ailing plans, a mass exodus was possible once the guarantees under ERISA became effective. At that point, ailing companies could shift their pension burden to the Pension Benefit Guarantee Corporation (PBGC), the insuring agency created by ERISA, and thus avoid leaving their retirees without any income. One estimate by the PBGC indicated it might have to fund as much as $4 billion in benefits if all troubled multiemployer pension plans folded—a sum far in excess of its assets. The guarantee corporation is financed through employer-paid premiums, and if too many claims push it into bankruptcy, the taxpayers would have to bail it out.

In recognition of the fact this legislation might need a series of revisions before becoming operative, Congress deferred the mandatory insurance covering multiemployer pension plan benefits until May 1, 1980 (Public Law 96–24). Until that date, the PBGC had discretion to undertake the payment of pension benefits to employees covered by terminated multiemployer plans.

As the date for implementing the provisions of insurance covering multiemployer plans drew near, concern grew that if the provisions of ERISA became effective for multiemployer plans on a mandatory basis, the PBGC would immediately be inadequately funded for purposes of covering anticipated plan terminations. Clearly, some action needed to be taken.

At the request of the administration, H.R. 3904 and S. 1076 were introduced in the House and the Senate. These proposals were designed to replace the multiemployer pension plan termination insurance provisions of ERISA. After several delays, an amended version of H.R. 3904 was signed into law on September 26, 1980 (Public Law 96–364). Among the many provisions of this complex bill were the following major changes:

—*Definition of multiemployer plan:* The definition is changed to provide that a multiemployer plan is a plan to which two or more unaffiliated employers contribute pursuant to collective bargaining agreements. Because the old definition required that no employer contribute more than 50 percent of the total plan contributions and that the plan not provide for certain benefits to be canceled when an employer stopped contributing, some plans previously determined to fall outside the definition now are subject to the multiemployer plan provisions.

—*Definition of insurable event:* The new law changes the insurable event from the termination of a plan to insolvency. The PBGC is required to provide financial assistance to insolvent multiemployer plans (whether or not terminated) where the assistance is needed to enable the plans to pay basic benefits.

—*Higher insurance premiums:* The new law provides that the annual per-participant premium for multiemployer plans is to increase from the present $0.50 to $2.50 over a 9-year period to

assure that the PBGC will have sufficient assets to pay benefits up to the guarantee level for those plans that do become insolvent.

—*Troubled plan:* The law now places certain financially troubled plans in a status of "reorganization." Once a plan enters reorganization, a minimum contribution requirement, which usually requires an increase in employer contributions, applies to the plan. The minimum contribution requirement is phased in to protect employers against very large increases in contributions for a plan year. In the case of a plan considered overburdened because it has a high proportion of retirees, the additional funding required under the minimum contribution requirement is reduced by an overburden credit.

—*Benefit reductions:* Trustees of multiemployer plans in serious financial difficulty may reduce or eliminate benefit increases that have been in effect for fewer than 5 years.

—*Benefit guarantees:* The act includes special benefit guarantee levels for multiemployer plans. Benefits under plans that met certain funding requirements in the 10 years preceding the effective date of ERISA's funding rules are guaranteed at a higher level than benefits under plans that did not meet those requirements. For the former plans, monthly benefits are guaranteed at the rate of 100 percent for the first $5 of the benefit and 75 percent of the next $15. Guarantees for the latter, underfunded plans are set at 100 percent of the first $5 of monthly benefits and 65 percent of the next $15.

—*Supplemental guarantees:* The act directs PBGC to set up a supplemental guarantee program which would allow multiemployer plans that meet certain qualifications to pay an additional insurance premium and obtain greater benefit guarantees.

—*Delinquent contributions:* The act strengthens the ability of trustees to collect delinquent contributions by making the employer's duty to contribute to the plan an obligation under ERISA. Plans that prevail in court actions to recover delinquent contributions will be entitled to receive court costs, attorney fees, interest, and liquidated damages as well.

—*Withdrawing employers:* The law now institutes liability for employers who withdraw from plans that have unfunded vested liabilities. A withdrawing employer's liability is its fair share of the plan's total unfunded vested liability and is to be paid back to the plan in annual installments for a period not exceeding 20 years.

An amendment offered by Senator Pete V. Domenici provides a "grandfather clause" for present pensioners and those very near retirement who would find it very difficult to make alternative provision for financial security in retirement:

> For people who, on July 29, 1980, were (a) receiving pensions, or (b) vested and within 3 years of normal retirement age, benefits at the level in effect on that date are guaranteed up to the limits for single-employer plans (currently, $1,159 a month). That provision does not apply if the plan terminates by mass withdrawal.

B. President's Commission on Pension Policy Makes Interim Recommendations

As discussed above in the section on social security, the President's Commission on Pension Policy issued two 1980 interim reports (in May and in November). Besides their recommendations on social security, the Commission made several proposals aimed at improving the private pension system in the United States.

Perhaps their most far-reaching suggestion was that "serious consideration should be given to the establishment of a minimum advance-funded pension system. Such a program could be thought of as an advance-funded tier of social security that would permit contracting out to pension plans that wanted to meet its standards or as a universal, employee pension system with a central portability clearinghouse."

In announcing their first set of recommendations, Commission Chairman C. Peter McColough, who is also chief executive officer of Xerox Corp., pointed out:

> More people are expected to live longer in retirement in future years. Therefore, the problems associated with our enormous pension programs in this country will increase. Steps must be taken soon to address the issues and design solutions to our difficulties in the area. We are convinced of the need for a comprehensive U.S. pension policy.

Other recommendations issued by the Commission included:

—The replacement of preretirement disposable income from all sources is a desirable retirement goal.

—The greatest emphasis should be placed on expanding pension coverage rather than providing full inflation protection to some at this time.

—The tax treatment of employee and employer contributions to pension plans and earnings on these contributions should be the same.

—The concept of a tax credit for low- and moderate-income people to encourage individual retirement saving and employee contributions to plans should be given serious consideration.

III. PUBLIC PENSIONS

A. Civil Service Retirement

1980 was not a quiet year for civil service retirees. In addition to rising concerns over the possibility of some type of merger with the social security system, retired civil service workers were also forced to fight off very serious attempts to remove their twice yearly cost-of-living adjustments (COLA's).

The question of "universal coverage," or bringing civil service employees under the social security system, received much attention when the Universal Social Security Coverage Study Group released their final report in March 1980. However, since the Carter administration announced shortly thereafter that they had no plans to take any action, it soon became clear that no serious legislative effort to

enact any form of universal coverage was likely in the remaining days of the 96th Congress. With a new administration entering in 1981 and with the elections of 1980 over, renewed interest in universal coverage could emerge.

The issue of reducing to once per year, the twice yearly COLA for Federal, postal, and military retirees was a quite different matter. Originating as part of the Carter budget requests for fiscal year 1981, the move to reduce the twice yearly COLA's was successfully engineered through both the House and Senate Budget Committees.

The move to reduce the COLA's was carefully designed to be part of the mammoth Budget reconciliation bill. Thus, by combining it with a large number of additional cutbacks, legislators were voting to balance the budget by voting for the whole "package" of bills. The many interest groups lobbying to retain their twice-yearly COLA's were naturally anxious to devise a way to force a vote on the COLA issue alone.

After several setbacks in attempting to execute this strategy, their efforts were finally successful. In late August, before the final reconciliation bill was scheduled to go to the House floor for a vote, supporters of the twice-yearly COLA were able to garner enough votes in the House Rules Committee to permit introduction of an amendment on the floor forcing a yes or no vote on the COLA issue. The amendment to retain the double COLA (introduced by Representative Robert Bauman of Maryland) easily won by a vote of 309 to 72.

Largely as a result of this vote, Senate and House conferees eventulaly eliminated any reference to the twice-yearly COLA issue in the version of the Budget Reconciliation Act of 1980 (H.R. 7765).

B. "Look Back" and "Prorationing"

In its final version, H.R. 7765 (Public Law 96–499) did make two alterations affecting the manner in which initial benefits for civil service retirees are calculated.

For several years, upon retirement, civil service workers were able to rely on a provision known as the "look back." The "look back" permitted each retiree to add to his initial retirement benefit the cost-of-living adjustment most recently awarded to civil service pensioners. Under the twice-yearly COLA system, each retiree saw his benefits adjusted each October and each March. Therefore, a worker retiring in late September could "look back" to the previous March 1 and add that COLA to his initial retirement benefit.

On top of the "look back," each retiree was eligible for the full semiannual COLA after he retired. In other words, he could retire on September 30, receive his benefit, and 1 day later (on October 1) be eligible for a cost-of-living adjustment—even though he had only been retired for 1 day. By combining both of these advantageous provisions, any prospective civil service retiree could carefully time his retirement to receive two COLA's virtually at once. For example, a worker retiring in 1980 could have timed his retirement to occur on September 30, 1980. By so doing, his initial benefit would have been increased by 6 percent immediately ("looking back" to the March 1, 1980, COLA), and 1 day later (on October 1, 1980) his new benefit including the 6-

percent COLA would have been increased by 7.7 percent. In short, although retired for only 1 day, the retiree would have received a 13.7-percent increase to his benefit to keep him even with inflation. In effect, he would start 13.7 percent ahead of inflation (about 14.2 percent, considering the effect of the second COLA on the first.)

H.R. 7765 brought a halt to both of these practices. The "look back" is no longer available to civil service retirees, and their first semi-annual COLA is now prorated. More specifically, for every month (or every fraction of a month) that a pension was payable prior to the first COLA, the beneficiary is entitled to one-sixth of the new increase. For example, if a retiree had been retired for 3 months when the next COLA became effective, he would be eligible for one-half the increase.

C. Railroad Retirement Pensions

On January 1, 1981, the retirement payroll tax rate for railroad employees increases from 6.13 to 6.65 percent. The payroll tax rate for railroad retirement is the same as for social security and both the rate and the amount of earnings are subject to the tax increase whenever social security taxes rise.

The most central concern of the railroad retirement system is its fiscal soundness. Reports from the Chief Actuary of the Railroad Retirement Board indicate that, based on updated assumptions, the railroad retirement account will become insolvent under current law in 1983, and under more pessimistic assumptions, could run out of funds early in 1982.

Although efforts in the 96th Congress (notably S. 2979) were unsuccessful in shoring up the actuarial soundness of the system it is expected that Congress will take steps to improve the system as it will for social security.

In December 1980, Congress passed H.R. 8195 (Public Law 96–582) which directed both management and labor representatives of the railroad industry to present joint recommendations.

Specifically, the law states:

> No later than March 1, 1981, representatives of employees and representatives of carriers, acting through a group designated by them, shall submit to the Senate Committee on Labor and Human Resources and the House of Representatives Committee on Interstate and Foreign Commerce a report containing their joint recommendations for further restructuring of the railroad retirement system in a manner which will assure the long-term actuarial soundness of such system.

D. Cost-of-Living Increases Extended

The federally administered railroad retirement system consists of two component parts or "tiers." Tier I is designed to be equivalent to social security, and is financed in the same way. Cost-of-living increases to tier I are automatically applied as they are for social security.

Tier II is an amount in addition to tier I and is analogous to a private, employer-paid pension. It is financed by a 9.5-percent payroll

tax paid entirely by the railroad employer. The Railroad Retirement Act of 1974 provided for four specific cost-of-living adjustments in tier II. The last of the four specific cost-of-living increases approved by the 1974 law became effective June 1, 1980. No further increases were approved.

However, as part of H.R. 8195, Congress approved an additional, or fifth cost-of-living adjustment, to become effective on June 1, 1981.

E. Military Pensions

Prior to the passage of S. 91 (Public Law 96–402), an offset was required for survivors entitled to benefits under the military survivor benefit plan (SBP). Benefits under the SBP payable to a widow age 62 or over, or to a widow under age 62 if she is a mother of one dependent child, were reduced by an amount equal to a social security benefit computed solely on the basis of her deceased husband's military record.

S. 91 does not change the requirement for an offset but limits the maximum amount of the offset to 40 percent of the benefit payable to the spouse under the survivor benefit plan. The 40-percent ceiling on reductions in the Department of Defense payments to the survivor will be of very significant benefit to a substantial number of survivor beneficiaries.

IV. SUPPLEMENTAL SECURITY INCOME

During 1980, a cost-of-living increase of 14.3 percent was added to all supplemental security income (SSI) payments effective July 1, 1980. As mentioned previously, social security and SSI checks increase automatically each year if the Consumer Price Index (CPI) rises by 3 percent or more over a specified period.

As a result of the July increases, the maximum Federal SSI payments increased as follows:

	Old payment	With 14.3 percent increase
Individual	$208.20	$238
Couple	312.30	357

It should be noted that most States provide payments supplementing the Federal SSI payment levels for some or all recipients.

H.R. 8406: New Transfer of Assets Rule

On December 28, 1980, President Carter signed into law H.R. 8406 (Public Law 96–611) which contains a new "transfer of assets" rule which penalizes applicants for SSI and medicaid who transfer an asset for less than fair market value.

The new law amends section 1613(c) of the Social Security Act by requiring the Social Security Administration to consider as available any asset of an applicant for SSI which has been transferred for less than fair market value in the previous 24 months prior to application,

unless the applicant can demonstrate by "convincing evidence" that the asset was disposed of for reasons other than to obtain eligibility for SSI. In other words, the Social Security Administration must presume that the asset is still available, and the burden of proof is on the applicant to show that the asset was transferred for some other purpose. Applicants who cannot meet this burden of proof will be denied eligibility for a 24-month period from the time of the transfer.

Since the Department of Health and Human Services has not yet issued regulations to implement this new provision, it is uncertain whether this rule will be applied retroactively. For SSI, the new rule takes effect on March 1, 1981. For an application filed after March 1, it is not clear whether the statute permits consideration of transfers, which occurred prior to March 1, 1981. However, the statute should not affect applicants who both transfer an asset and apply for SSI before March 1, 1981.

V. AGE DISCRIMINATION AND MANDATORY RETIREMENT

Although 1980 was not a year of major breakthroughs in the area of age discrimination and mandatory retirement, there were some significant developments. The age of retirement for Foreign Service workers was raised from 60 to 65; Congress expressed its displeasure with the policy of restricting consideration of those over 60 for appointment to the Federal bench; and a significant conflict of interpretation developed between the Department of Labor and the Equal Employment Opportunity Commission (EEOC) concerning the accrual of benefits for workers who continue to be employed after the normal retirement age.

A. Foreign Service Act of 1980

Signed into law by President Carter on October 17, 1980, the Foreign Service Act of 1980 (H.R. 6790) raised the mandatory retirement age for members of the Foreign Service from age 60 to 65. Retirement benefits are provided for a qualified participant with at least 5 years of service credit under the system, excluding military service.

There are two exceptions to the mandatory age of retirement at 65: (1) Presidential appointees may continue to serve until their stated term ends, and (2) in matters of public interest, the Secretary of State may defer retirement at age 65 for a period up to, but not to exceed, 5 years.

Raising the age to 65 brought additional benefits to Foreign Service workers. Traditionally, in the case of workers who died or became disabled and who had not accrued 20 years of service credit for their retirement, the law provided for automatic accrual of years of credit equal to the difference between the age of the deceased or disabled worker and age 60. Under the new act, years of service credit will be provided to age 65. Thus, for example, a deceased worker at age 55 would be eligible for an additional 10 years of service credit instead of 5.

B. Candidates for Federal Judgeships

Nominees for lifetime appointment to Federal judgeships have in recent years been subjected to a policy which restricted consideration of possible candidates over age 60. This policy was soundly criticized by both the House and the Senate during 1980.

The Standing Committee on Federal Judiciary of the American Bar Association has a policy that states as follows:

> An individual 60 years of age or older is not recommended for an initial appointment to a lifetime Federal judgeship unless in excellent health and evaluated as "well qualified" or "exceptionally well qualified." In no event are persons over age 64 recommended for initial appointment.

The Department of Justice substantially agreed with this policy.

Led by Representative Claude Pepper, chairman of the House Select Committee on Aging, both Houses of Congress expressed their strong opposition to this policy. The Senate version, S. Res. 374, introduced by Senator DeConcini, passed by a vote of 97–0 on April 1, 1980. A similar provision, H. Res. 693, introduced by Congressman Pepper, passed the House on November 17, 1980. The resolutions expressed the sense of each House that the Standing Committee on Federal Judiciary of the American Bar Association and the Attorney General should "take all measures necessary to end discrimination against potential lifetime Federal judges who do not qualify solely as a result of age barriers."

C. EEOC Proposals To Require Benefit Accruals Past Normal Retirement Age

The Equal Employment Opportunity Commission (EEOC) proposed changes to the Labor Department's Interpretive Bulletin on Age Discrimination in Employee Benefit Plans that would require benefit accrual and plan contributions for employees who work past the normal retirement age. These proposals were submitted to the Labor Department, the Internal Revenue Service, and the President's Commission on Pension Policy on April 25, 1980.

The Equal Employment Opportunity Commission, which assumed responsibility from the Labor Department for enforcement of the Age Discrimination in Employment Act (ADEA) in July 1979, proposed changes to remedy what it viewed as the inequities older participants experience under the Labor Department's interpretation of the law.

The 1978 amendments to the ADEA raised the mandatory retirement age in private industry from 65 to 70 (Public Law 95–256). The central question at issue in the EEOC's proposals was whether or not employees should be required to accrue additional benefits for employees who continue to work past the normal retirement age.

In short, the Labor Department had said there was no requirement for accrual (final regulations published in the Federal Register on May 25, 1979). The EEOC proposal would make four basic changes in the Labor Department interpretations of the law:

(1) Prohibit employers from excluding from participation in defined benefit plans employees hired within 5 years of normal retirement age.

(2) Require contributions to defined contribution plans for employees who work beyond normal retirement age.

(3) Require the crediting of years of service under a defined benefit plan for years worked after normal retirement age; and

(4) Set up alternatives for actuarial adjustment of benefits for employees who work past normal retirement age.

Following review by the appropriate Federal agencies, the EEOC was preparing to vote on the measure on October 21, 1980. However, a last-minute, 18-page letter (dated October 17, 1980) from Labor Secretary Ray Marshall to EEOC Chairman Eleanor Holmes Norton led to a postponement of the vote. By year's end, the EEOC had put off the issue indefinitely. According to the letter, the Labor Department felt that the EEOC's interpretation of the ADEA was contrary to the legislative history of the act, and conflicted with some of the technical requirements of the Employee Retirement Income Security Act (ERISA).

More specifically, Secretary Marshall argued that employers affected by the proposed changes would be faced with much higher costs in order to fund the benefits required. In the view of the Labor Department, the legislative history of the 1978 ADEA amendments was contrary to the direction proposed by the EEOC. Quoting the Senate report on these amendments (S. Rept. No. 95–493, 95th Cong., 1st sess. (1977), pp. 13–16) the Marshall letter said that the ADEA amendments do not "require the accrual of additional benefits or the payment of actuarial equivalent of normal retirement benefits to employees who choose to work beyond the plan's normal retirement date."

While it remains uncertain what effect the new Reagan administration will have on the issues of accrual of benefits after normal retirement age, clearly the obvious disagreements over legislative history suggest unlikely changes without some form of congressional action.

VI. EMPLOYMENT—NEW HEARINGS: "WORK AFTER 65: OPTIONS FOR THE 80's"

Passage of the 1978 amendments to the Age Discrimination and Employment Act has had a major impact on the issues of aging, work, and retirement. The mandatory retirement age for Federal employees was completely eliminated and the age in the private sector was raised from 65 to 70 (Public Law 95–256). The potential impact of greater employment of the older worker is significant not only for today's older worker, but for the future labor force of the whole Nation.

With the post-World War II baby boom soon to become the senior boom at the beginning of the next century, it is essential to begin exploring new ways to stimulate continued employment for older workers both before and after age 65.

In an effort to shed light on this issue of growing social and economic importance, the Senate Special Committee on Aging initiated a new series of hearings on "Work After 65: Options for the 80's."

Despite sweeping changes in the mandatory retirement law in 1978, there is no hard evidence yet to indicate that substantial numbers of older workers are delaying retirement and working longer.

It is important to bear in mind that, in considering ways of increasing employment opportunities for the older worker, the committee in no way was suggesting that opportunities for early retirement should be eliminated or reduced. For many people, early retirement is both necessary and viable. What is of significant policy concern is that so few alternatives are currently available.

The primary purpose of this new series of hearings is to learn about the problems facing older persons who want to continue to work. A major concern is the future implication of current trends and present policies. It is the committee's view that new efforts to encourage greater opportunities for continued employment of older persons will be both human effective and cost effective.

"Human effective" suggests that we should provide better opportunities for older workers, both before and after age 65, to follow their own desires and preferences, to use their skills, experience, and learning in pursuit of their own financial and psychological independence.

There is a great deal of evidence, from several recent national public opinion surveys,[8] clearly indicating that many older citizens want to continue working: Some prefer full-time work, others prefer part-time employment to supplement their pension and social security benefits, and some, of course, are perfectly happy with full retirement, which is their right. But the general preference for expanded work opportunities is strikingly clear.

The costs of retirement systems are becoming more and more obvious every day. Concern over the financing of the social security system and the threatened collapse of various pension funds are but two examples of the cost problem. Over the past several decades, fewer and fewer older workers have stayed in the active labor force. According to a Department of Labor study in 1947, 48 percent of male workers age 65 and older were in the labor force, a percentage which declined to only 22 percent by 1974. Estimates made prior to the 1978 amendments projected that such participation would drop to 19 percent by 1990.

A growing older population, combined with increased longevity and less and less labor force participation, means an escalating reliance on social security and pension systems, which are already under great financial pressure. What better way is there to ease this problem than by recognizing that millions of older persons prefer to work, and by encouraging job opportunities for them?

The first two hearings in the series were held in Washington, D.C., on April 24, 1980, and May 13, 1980, respectively. On the first day the committee heard from a panel of distinguished experts concerning the economics and the psychology of the older worker. The second

[8] National Council on the Aging, "The Myths and Realities of Aging in America" (Washington, D.C., 1974); Johnson & Higgins, "Study of American Attitudes Toward Pensions and Retirement: A Nationwide Survey of Employees, Retirees, and Business Leaders" (New York: 1979); Social Security Advisory Council, "A Nationwide Survey of Attitudes Toward Social Security" (Washington, D.C.: 1980); President's Commission on Pension Policy, "Preliminary Findings of a Nationwide Survey of Retirement Income Issues" (Washington, D.C.: 1980); NRTA–AARP, "DataGram": A Periodic Publication of the National Retired Teachers Association—American Association of Retired Persons, 1980.

hearing heard an equally distinguished panel of corporation presidents and vice presidents whose companies have had successful experiences with older worker policies.

Despite the somewhat different backgrounds and orientations of various witnesses at these two hearings, two general themes emerged throughout their testimony. These two themes also represent conclusions which appear to have the support of all the witnesses.

First, there is great value both to the worker and to the employer in encouraging employment opportunities for the older worker. While older employees obviously gain from increased income, there is a substantial psychological benefit that is also produced. The older person who desires to work and finds a suitable job has a much more positive feeling about himself and a stronger sense of contribution to his employer and to his community.

Employers who have been in the forefront on this issue, which include the four companies that testified at the second hearing, report no great problems or ill effects from allowing older employees to remain on the job. On the contrary, the witnesses consistently remarked that their older employees were among their most loyal and productive workers. Companies such as Polaroid and Bankers Life & Casualty, which have never had mandatory retirement, are not overrun by thousands of old workers of declining competence. In fact, the corporate witnesses report just the opposite: A self-selection process has evolved in which the less healthy and less motivated employees are typically the first to want to retire, and the competent, motivated employees are the ones who often choose to stay on.

The second major conclusion to emerge from hearings is that older workers are the victims of myths and stereotypes. Dr. K. Warner Schaie, a psychologist who is director of the Gerontology Research Institute of the Andrus Gerontology Center at the University of Southern California, reported results from his 21-year longitudinal study of age changes in competence and learning ability. He concluded that there is no evidence of systematic across-the-board poor health, higher accident rates, lower productivity, reduction in learning ability, or lowered value of retraining as a consequence of normal aging.

At earlier Committee on Aging hearings on "How Old Is Old? The Effects of Aging on Learning and Working," this point was stressed. Carl Eisdorfer, M.D., Ph. D., of the University of Washington School of Medicine, pointed out:

> It is difficult for us to come up with conclusions because one of the few truisms about aging is that the older you get, the larger the variance in the population. That means we have a problem arriving at significance because dealing with statistics means incorporating the variation in the data. On the other side, it means that while a lot of older persons are showing a lot of deficit, there are also a lot of others that are showing relatively little, if any, deficit. That wide span is a very important concept.[9]

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[9] U.S. Congress. Senate. Senate Committee on Aging. Hearing on "How Old Is Old? The Effects of Aging on Learning and Working," Apr. 30, 1980, Washington, D.C. (Senator John Glenn presiding), p. 10.

Reubin Andres, M.D., of the National Institute on Aging, agreed:

> There is no adult plateau period during which no aging decrements occur. Even 30-year-olds cannot perform as well as 20-year-olds in many of the tests that are done. A second truism is that variability in functions in system after system is remarkably large, so that there are some elderly people who perform quite as well as average middle-aged adults on specific tests, and conversely some middle-aged adults who in certain specific ways resemble an average elderly person.[10]

Ironically the four corporate witnesses at the second hearing agreed that a major obstacle to the employment of the older worker is the persistence of the very myths that the scientific research has shown to be false. Harold Page, vice president for personnel of Polaroid, stated bluntly that "our observation is that the story that older workers have poor attendance is purely a myth." As to accidents, Gerald Maguire, vice president of corporate services for Bankers Life & Casualty of Chicago, said that "our compensable time lost is about somewhere between a third and a fifth for the older worker as opposed to the regular worker." It is relevant to again note in this context that neither Polaroid nor Bankers has ever had a policy of mandatory retirement.

Why do such myths persist? One answer is that the phenomenon of the older worker on a large scale is relatively new, and is getting growing attention as the legal barriers to older employment have diminished. Another, perhaps more direct answer was given by C. Peter McColough, chief executive officer of Xerox, and Chairman of the President's Commission on Pension Policy. He said that for many corporate executives there has been a reluctance to look at the entire problem. "It is like a lot of things in our society—until you really focus in on something you don't understand it."

One of the most direct statements of corporate experience refuting the negative stereotypes of the older worker came in the third hearing held in Orlando, Fla., July 9, 1980. George Tschudi, personnel manager of the Grumman Aerospace Corp. facility in Stuart, Fla., described his experience in rehiring his company's own retirees. When asked about the stereotype of the older worker as accident-prone, absence-prone, and unable to benefit from retraining, Mr. Tschudi said that none of those conditions held true in his experience. In fact, Grumman's experience was just the opposite: "Our retired employee who comes back to work has a consistently better attendance record than our regular employees," and "some of these people have done as well or better than some of the people who were younger and being trained for that same task." In sum, Mr. Tschudi agreed it was good "bottom line" corporate management practice for Grumman to retain older employees for a longer time, and to rehire retired employees.

Clearly one of the important conclusions to emerge from these hearings is the need to inform the public, as well as private and public

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[10] Ibid, p. 5.

employers more generally, that these negative stereotypes are indeed myths and are supported neither by research evidence nor by the experience of many employers. Yet it is important to note again that this orientation does not suggest that normal retirement, or even early retirement, should be withheld from those workers who so choose it. For those millions of older persons who have expressed either the desire not to retire or a preference for partial retirement combined with part-time employment, it is clear that planning must be initiated to explore the various options.

It is also apparent that such exploration must be started sooner rather than later. As Karl Kunze, chairman of the National Institute on Age, Work, and Retirement of the National Council on the Aging, said in the first hearing, "stereotypes about older people and their capabilities took decades to work themselves into our consciousness and they will not be excised overnight."

The creation of work opportunities, as witnesses pointed out, often requires an innovative examination of the older worker within the work situation. As Dr. Schaie noted, the particular strengths of the older worker can be maximized, and weaknesses minimized, when employers make some effort to match the worker with the job.

That such is possible was described by Jerome Rosow, president of Work in America Institute, Inc., and a former Assistant Secretary of Labor. Mr. Rosow described a study by his institute which surveyed 170 organizations, and which produced case studies of 69 innovative older worker programs in organizations representing over 2.5 million employees. He described six general types of innovative approaches to older worker employment which were identified in organizations including employers in both the public and private sectors. The six types are: Part-time work, phased retirement, second career training, job redesign, reentry workers, and older worker oriented job-finder organizations.

A major outcome of these hearings, then, is the evidence that one of the primary obstacles to the employment of the older worker is a set of negative myths and stereotypes denigrating the older worker's ability to function effectively. As several of the witnesses said, one major response would be a program of education and incentives aimed at employers to encourage the development of options for the older worker.

The general policy response to this set of issues must be located in cooperation between government and employers. New government employment programs, in an era of increasing budget consciousness, are less and less likely or desirable. Therefore, to reverse or slow down recent trends toward early retirement, and to promote and make available options for a longer worklife for older persons, the major thrust is likely to be in some form of partnership between government and private industry. The contours of such a cooperative arrangement will be a continued focus of the committee in future hearings.

In conclusion, the hearings suggest that Congress has a responsibility to follow up on its success in limiting the discriminatory practices of mandatory retirement. Even if all age-based mandatory retirement becomes legally prohibited, the Congress still has the responsibility of encouraging a social and economic environment in which

employers hire the older worker. In short, to paraphrase Pension Commission Chairman McColough, encouraging increased work force participation by older persons through more availability of full-time and part-time employment opportunities must become a matter of national policy.

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Chapter 3

FEDERAL HEALTH PROGRAMS

CHAPTER HIGHLIGHTS

A continued emphasis on finding ways to control the escalating costs of Federal health programs eclipsed efforts to significantly expand Federal health benefits for the elderly. Some liberalization of medicare benefits was passed by Congress, primarily in home health, but tighter administrative controls were also required.

Committee on Aging hearings entitled "Aging and Mental Health: Overcoming Barriers to Services" resulted in a number of amendments to the Mental Health Systems Act to improve community mental health services to the elderly, although legislation to ease restrictions on medicare coverage for mental health services did not pass Congress.

I. MEDICARE: THE DILEMMA OF RISING COSTS AND INCREASING GAPS

Overall national health spending continues to rise at a rapid rate, with a significant portion paid by medicare. At the same time, older Americans face continued increases in out-of-pocket health care payments. The 96th Congress passed a number of medicare amendments, including significant expansions of medicare reimbursement for home health services, but other medicare reforms strongly supported by the elderly and major aging organizations were dropped during final congressional deliberations in an effort to cut overall program costs.

A. Cost of Health Care: 1979 and Beyond

Total national health expenditures, public and private, for calendar year 1979 reached $212.2 billion, an increase of 12.5 percent over 1978 expenditures.[1] Total national expenditures are projected to be $245 billion in 1980, and at current spending trends, reach $758 billion by 1990.

The largest portion of total expenditures are for hospital care: $85.3 billion in 1979, estimated to be $97 billion in 1980, and projected to reach $335 billion by 1990. Total public expenditures for hospital care in 1979 were $47.7 billion. Medicare's portion of these public expendi-

[1] The Health Care Financing Administration prepares an analysis of national health expenditures each year. The most current figures available are for calendar year 1979. All expenditures for 1979 cited in this section are from "National Health Expenditures, 1979," Health Care Financing Review, summer 1980. Estimates for 1980 and future years are from "Projections of National Health Expenditures: 1980, 1985, and 1990, "Health Care Financing Review, winter 1980. Office of Research, Demonstrations, and Statistics, Health Care Financing Administration, U.S. Department of Health and Human Services.

tures was $21.7 billion, or 25 percent of all personal health care payments made to hospitals.

Payments for physicians' services comprise the second largest category of total public and private national health expenditures: $40.6 billion in 1979, estimated to be $45 billion in 1980, and projected to reach $129 billion in 1990. Public expenditures for physicians' services in 1979 were $10.6 billion, with medicare accounting for $6.4 billion, or 16 percent of all health care payments made to physicians.

Nursing home services continue to be the fastest growing category of total national health expenditures: $17.8 billion in 1979, estimated to be $22 billion in 1980, and projected to reach $76 billion in 1990. Public expenditures for nursing home care in 1979 were $10.1 billion. Medicare payments accounted for only $373 million of this total, with the bulk of public payments coming from medicaid. Total Federal and State medicaid payments to nursing homes in 1979 were $8.8 billion. The Federal medicaid share was $4.8 billion.

B. The Medicare "Payment Gap"

The Committee on Aging's annual report for 1979, in a section entitled "The Individual View: Frustration With Medicare," summarized a number of widely perceived problems with the medicare program as viewed by medicare beneficiaries.[2] Witnesses at a committee hearing on "Federal Paperwork Burdens, With Emphasis on Medicare" cited the following problems: Dissatisfaction with the amount of medicare benefit payments, including very high rates of reduction on claims filed; broad confusion over program benefits; increasingly low medicare "assignment" rates; and frustration with handling of claims by medicare part B carriers, including lengthy delays in payment, difficulties in obtaining information, and a cumbersome appeals process.

A recent report published by the House Select Committee on Aging cited the same problems, along with continued gaps in medicare coverage for important health services—such as home care, nursing home care, prescription drugs, and preventive health services—and questioned whether medicare was viewed by many elderly as a "broken promise."[3] The General Accounting Office (GAO) also submitted a report to the Senate Committee on Aging during the year detailing a number of areas in which the Comptroller General felt elderly medicare beneficiaries were being subjected to inequitable reductions in their medicare claims.[4]

Medicare's share of all personal health expenditures for the elderly is about 40 percent, including payments for hospital stays and physician services. Much of the attention, and the complaints, have been focused on medicare payments for physician services (part B)—where medicare payments for covered services represent only 31 per-

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[2] "Developments in Aging: 1979," part 1, pp. 55–59.

[3] U.S. Congress. House of Representatives. Select Committee on Aging. "Medicare After 15 Years: Has It Become a Broken Promise to the Elderly?" (Washington, Nov. 17, 1980).

[4] U.S. General Accounting Office. "Reasonable Charge Reductions Under Part B of Medicare"; Report to the Senate Committee on Aging and the Secretary of the Department of Health and Human Services by the Comptroller General of the United States. Washington, 1980 (HRD–81–12, Oct. 22, 1980).

cent of all physician charges to medicare beneficiaries.[5] The major reasons for this declining percentage of medicare payments for physician services under the medicare part B program are discussed below.

1. PREMIUM, COINSURANCE AND DEDUCTIBLE INCREASES

By law, the medicare coinsurance and deductible amounts which beneficiaries must pay are increased each year. Under the part A program (hospital insurance), the amounts each medicare beneficiary must pay out-of-pocket increased by 13.3 percent on January 1, 1981. The initial deductible for part A hospital insurance was increased to $204, $24 more than the 1980 charge of $180. Daily coinsurance charges for long-term hospital stays and skilled nursing facility stays also increased by 13.3 percent.

On July 1, 1981, the basic monthly premium paid by medicare beneficiaries for medicare supplementary health insurance (part B) will increase by 14.5 percent, from the current $9.60 to $11. Beneficiaries must also pay a $60 deductible each calendar year, and a coinsurance charge of 20 percent of the allowed charge for all covered services. In 1975, the total beneficiary liability for premiums, deductibles, and coinsurance charges was about $3.2 billion.[6]

2. DECLINING ASSIGNMENT RATES AND HIGH "REASONABLE CHARGE" REDUCTIONS

Under part B of the medicare program, physicians can either "accept assignment"—billing medicare directly for services provided and agreeing to charge the beneficiary no more than medicare pays—or bill the medicare beneficiary directly who then files a claim for reimbursement. When the medicare beneficiary is billed, the amount submitted is frequently in excess of what medicare allows and the difference must be paid out-of-pocket by the beneficiary.

This difference between submitted and allowed charges on unassigned claims, and the overall proportion of medicare claims which are submitted on an unassigned basis, has been increasing steadily since medicare's inception.

The percentage of unassigned claims has increased to about 50 percent from about 35 percent in the early years of medicare (1969 rate). Assignment rates are lower for the aged than for disabled medicare beneficiaries (47 percent of all physicians' charges for the aged and 62 percent of all physicians' charges for the disabled) and vary considerably by area of the country, from a low of 20 percent in South Dakota to a high of 82 percent in Rhode Island.[7]

During fiscal year 1979, medicare beneficiaries had to pay over $1.1 billion for the difference between submitted and allowed charges on these unassigned claims. This beneficiary liability was $882 million in fiscal year 1978, compared to $433 million in 1975, and $50 million in 1968.[8]

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[5] U.S. Department of Health and Human Services. Health Care Financing Administration. "Physician's Charges Under Medicare: Assignment Rates and Beneficiary Liability," Health Care Financing Review, winter 1980.
[6] Ibid.
[7] Ibid.
[8] Ibid.

These amounts represent the overall difference between what medicare considers "reasonable" charges and what physicians charge medicare beneficiaries for their services. In 1979, 81 percent of all unassigned claims submitted for payment by medicare beneficiaries were subject to a reasonable charge reduction. In 1975, 69 percent of all claims were reduced.

GAO Cites "Inequitable" Reductions

Early in 1980, the Committee on Aging requested a General Accounting Office (GAO) audit of a sample of unassigned claims processed by medicare carriers (private insurance companies under contract with the Federal Government to process and pay medicare claims) to determine whether or not beneficiaries were being reimbursed properly. In an October 1980 report to the committee, the GAO cited physician markups on laboratory work, medicare reimbursement policies on dual surgical procedures, and inadequate review of claims by carriers as three areas in which it believed beneficiaries were being subjected to inequitable reasonable charge reductions.[9]

Excessive physician markups on laboratory procedures performed by independent laboratories: 93 percent of all unassigned claims for laboratory work processed by Group Health, Inc., Miami, Fla., were marked up by an average of 105 percent. Unassigned laboratory claims processed through Florida Blue Cross had a net markup of 95 percent. Claims processed through Group Medical and Surgical Service in Texas showed a net markup of 89 percent, and those processed through Travelers Insurance Co., Mississippi, showed a net markup of 54 percent.

A physician can have laboratory work performed either in his or her own office, or send the work out to an independent laboratory, which in turn bills the physician for the work performed. The physician then adds this amount to the bill submitted directly to medicare or to the patient. These additional amounts, the markups, will not be paid by medicare (except for the physician's costs for paperwork and handling). The excess charge, an average of $13 per claim for one carrier, is added to the medicare beneficiary's out-of-pocket costs for laboratory tests.

If these findings from the GAO audit are routine practice across the country, and it appears that they are, the committee estimates that this practice adds $20 million a year to beneficiary out-of-pocket costs.

Noting that the American Medical Association (AMA) has stated that physician markups are unethical, GAO recommends making it a misdemeanor for physicians to add charges to laboratory bills. Alternatively, GAO recommends requiring laboratories to charge medicare directly, thereby removing physicians entirely from the billing process.

Public Law 96–499 (Omnibus Reconciliation Act of 1980) contains an amendment designed to make it easier for medicare carriers to accurately determine whether or not a claim submitted for laboratory services includes a markup, so that the amount billed can be appropriately reduced. No protections against the medicare beneficiary being subject to the overcharge however, were included in the new law.

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[9] U.S. General Accounting Office, "Reasonable Charge Reductions Under Part B of Medicare," op. cit.

Use of "fee-and-one-half" reimbursement policies for dual surgical procedures: GAO found that physicians routinely charge two full fees for two surgical procedures performed during a single operation, while medicare and many private health insurance payment practices usually limit the amount reimbursed to the full fee for the major procedure and partial amounts for other procedures performed during the operation. (The equivalent, in most cases, is a "fee and one-half"). The medicare beneficiary is required to pay the difference out-of-pocket to the surgeon. Based on the GAO's calculation of the cost to beneficiaries in the Washington, D.C., area, the committee estimates that this practice results in additional out-of-pocket cost to beneficiaries nationwide of at least $50 million each year.

Inadequate scrutiny of claims as they are processed by medicare carriers: In a review of claims paid by the District of Columbia carrier which showed reasonable charge reductions of $150 or more, the GAO found 42 percent of the claims had been incorrectly processed and the medicare beneficiary underpaid. The GAO recommended that more specific claims processing standards be established to provide assurances that beneficiaries are not underpaid.

This GAO audit finding that 42 percent of claims processed have errors resulting in incorrect payments to beneficiaries suggests that thousands of beneficiaries could realize higher reimbursements on part B claims if they questioned large reductions. The process of appealing carrier decisions, however, is not often used. Only about 2 to 3 percent of beneficiaries ever request a review, but half of those who do, receive increased reimbursement.

There are indications that the frustration of increasing out-of-pocket costs for all physician services, added to growing beneficiary sophistication about program procedures and avenues of recourse, will lead to a higher and higher volume of requests for review of claim determinations.

A hint of what this increased workload may mean for medicare carriers, and for the part B payment system itself as the program increases in complexity, may be seen by the case of EDSFC.

3. INADEQUATE CLAIMS REVIEW: THE RESULTS

Early in 1980, a rash of complaints from Illinois medicare beneficiaries about long delays in processing medicare part B claims and unanswered inquiries by the carrier (Electronic Data Systems Federal Corporation (EDSFC)) led to hearings by the Subcommittee on Health of the House Committee on Ways and Means.[10] EDSFC, which had been awarded an experimental medicare claims processing contract for the entire State in April 1979, was the lowest bidder for the contract. It did not have broad technical expertise or experience with the medicare program. By September 1979, official records showed 454,000 claims backlogged and pending. In March 1980, records indicated 110,000 additional backlogged items of correspondence from

[10] U.S. House of Representatives. Committee on Ways and Means. "Experimental Medicare Claims Processing Contract," field hearing, Subcommittee on Health, Chicago, Ill., Apr. 28, 1980. Congress has granted the Health Care Financing Administration authority to experiment with competitive fixed-price procurement for medicare claims processing contracts. Three contracts have been awarded in Illinois, Maine, and New York, on a demonstration basis. The GAO is now evaluating all three contracts, with a report to the Subcommittee on Health, House Committee on Ways and Means, scheduled during 1981.

beneficiaries. Under pressure to meet contract standards, changes were made, extra staff hired, and claims and correspondence backlogs appeared to be reduced. However, a later GAO investigation found that this pressure had led to some extraordinary measures, most of which escaped detection by contract monitors from the Health Care Financing Administration (HCFA).[11]

The GAO found that:

—EDSFC employees concealed unprocessed claims from an end-of-the-year review so they would not be counted as backlog by HCFA investigators.

—Thousands of letters from claimants were destroyed without response, to remove them from the backlog. A GAO sample found 44 percent of these letters were requesting reviews or submitting additional information for claims.

—Additional thousands of items of correspondence which had been partially reviewed at another location were destroyed rather than completed once they were returned to the main office. GAO found that 90 percent of a similar sample of mail in question was either a request for review or a claim. HCFA monitoring does not include any tests to determine if correspondence is answered.

—EDSFC employees allowed claims with known errors in them to be processed. HCFA performance standards requiring documentation of any such irregularities in processing were not enforced.

—Thousands of "Explanation of Medicare Benefits" forms which were returned by the post office as "undeliverable mail" were destroyed without any attempt to determine why they were incorrectly addressed. HCFA standards require such returns be analyzed to determine reasons for return, remail them, and pursue possible fraud and abuse problems. Based on a later sample, the GAO determined the returned mail which had been discarded contained other items, including correspondence and undelivered checks.

The GAO also found that of nine fair hearing officers employed by EDSFC, none were attorneys and only three had any college degree (in completely unrelated areas; home economics, journalism, and public administration). HCFA standards provide for "an attorney or other qualified individual with the ability to conduct formal hearings and with a general understanding of medical matters and terminology" and with thorough knowledge of the medicare program. Most fair hearing officers across the country are attorneys. HCFA had not evaluated the hearing officers' qualifications.[12]

The GAO strongly recommended an increased level of onsite contract monitoring and continual oversight of handling of reviews.

Many of these problems might have been avoided if the carrier had been more experienced with the medicare program, but similar allegations were recently made of a much more experienced carrier.

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[11] U.S. General Accounting Office. "Review of Alleged Questionable Actions by EDSF To Reduce Its Claims and Correspondence Backlogs Under Its Medicare Contract" (Report No. HRD–81–44, Dec. 16, 1980).

[12] On May 16, 1980, the U.S. District Court for the Northern District of California decided, in a nationwide class action, that medicare part B hearings presided over by employees of the private insurance companies that act as medicare carriers, whose decisions are final and cannot be appealed, violate the U.S. Constitution (*McClure* v. *Harris*, No. C–79–0201–WHO).

In December 1980, the Washington Star reported allegations by employees of the District of Columbia Blue Shield that, during 1978 and 1979, officials had withheld from 10 to 20 percent of all medicare claims—those with known high rates of error—from sample batches which were to be inspected by Federal officials as part of a quality assurance review. According to employees, the actions were taken at a time when the error rates of the carrier were high enough to threaten their contract agreement with HCFA.

C. The 1980 Medicare Amendments

The 96th Congress took final action on a number of amendments to both expand medicare coverage and cut back on program costs which are discussed below in section II. Some amendments of particular importance to the elderly, however, did not finally emerge from the 96th Congress. A summary of the most significant of these actions is discussed below.[13]

1. BENEFIT EXPANSIONS SIGNED INTO LAW

Expanded medicare coverage for home health services: A number of amendments which will significantly expand medicare coverage for home health services were signed into law on December 5, 1980 (Public Law 96–499).[14]

New medicare coverage for pneumococcal vaccine: An amendment to the medicare program to provide full reimbursement for pneumococcal vaccine was signed into law on December 28, 1980 (Public Law 96–611). The new coverage will be effective on July 1, 1981, and reimbursement will be available without copayment or deductible.

This change in medicare law represents an exception to the current exclusion of coverage for preventive immunizations and other preventive health services. (The medicare statute is directed toward treatment or diagnosis of specific illness or injury and therefore excludes payment for routine physical checkups, immunizations, health screening, etc., without specific statutory exception.)

Additional amendments: The following amendments, which become law during 1980 (Public Law 96–499) expand medicare coverage in certain specific areas:

—The annual medicare reimbursement ceiling for outpatient therapy services furnished by independently practicing therapists was increased from $100 to $500.

—Medicare payment is authorized for currently covered services which are provided by freestanding outpatient rehabilitation facilities. Present law recognizes coverage for a variety of rehabilitation services, such as physical, speech, and occupational therapy, as provided by qualified providers and incidental to other physicians' services. Comprehensive rehabilitation centers had not been recognized as providers prior to this change in the law.

[13] Significant changes in medicare reimbursement for home health and nursing home care are discussed in chapter 4, long-term care. In addition to amendments discussed here, many additional amendments passed were primarily of an administrative nature, and a full report can be found in U.S. House of Representatives, Report No. 96–1479, Omnibus Reconciliation Act of 1980, conference report, Nov. 26, 1980.

[14] See following chapter 4, long-term care, for full description of these amendments and other activities in home health during 1980.

—Medicare payment is now authorized to dentists who perform certain dental procedures which would otherwise be covered if performed by a physician. Prior to this change in the law, only certain surgical procedures related to the jaw were covered when performed by dentists. The change will allow payment to dentists for other already covered services, such as treatment of oral infections. No change is made, however, in the general exclusion from coverage of routine dental care.

—Medicare payment is authorized for treatment of warts on the feet (plantar warts). Previously, treatment for warts was covered only if they occurred on other parts of the body. The general exclusion of routine foot care from medicare coverage, however, continues to apply.

—Medicare payment is now authorized to optometrists for examination services in relation to aphakia—a condition of the eye in which the natural lens is absent. Prior to this change in the law, these same services were covered only when performed by a physician.

2. DECISIONS DEFERRED ON MENTAL HEALTH AND HMO'S

Even though legislation to expand medicare coverage for mental health services had passed the House of Representatives in 1978 (H.R. 3990), this legislation was deleted from the final package of amendments emerging from the 96th Congress and did not become law.[15]

During each of the last two Congresses, legislation has been considered to broaden the use of medicare payments to encourage more elderly participation in qualified health maintenance organizations.[16] The full House passed, on September 4, 1980, this provision as part of H.R. 7765, the Omnibus Reconciliation Act of 1980, but it was later dropped during a conference with the Senate.

This proposal has gathered increased support among Members of the Senate and is strongly endorsed by both the National Retired Teachers Association/American Association of Retired Persons and the National Council of Senior Citizens. It is expected that a similar measure will be reintroduced early in the 97th Congress.

II. CONTINUED EMPHASIS ON CONTROLS FOR MEDICARE-MEDICAID ABUSE

The effectiveness of State medicaid antifraud units received a favorable evaluation in 1980 and Federal funding was extended to allow additional time for the establishment of new units. Many States were also required to improve their management of the medicaid program,

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[15] See following section on mental health for full description of this legislation and other mental health legislation which was approved during the year.

[16] In 1978, S. 2676 and H.R. 11461 were proposed by the administration. The House bill received 1 day of hearings by the Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce. In 1979, S. 1530 and H.R. 4444 were proposed by the administration. Hearings were held by the House Committees on Interstate and Foreign Commerce and Ways and Means and the amendments were reported to the floor as part of H.R. 4000 and H.R. 7765. The Senate bill was cosponsored by Committee on Aging members Heinz, Bradley, Chiles, Church, Cohen, and Glenn. See "Developments in Aging: 1979," part 1, pp. 66–69, for a full discussion of the proposal as well as Committee on Aging hearings conducted by Senator Heinz.

with a 1982 deadline set for all States to have medicaid management information systems in place. Additional amendments to the Social Security Act were passed by Congress to improve administrative controls over the medicare and medicaid programs, for which combined expenditures were about $52 billion in 1979. Special attention was given to the medicare home health program with a number of administrative changes made to tighten program controls.

A. State Medicaid Fraud Control Units

The 1977 Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95–142) authorized 90-percent Federal medicaid funding for a period of 3 years (1978–80) as an incentive for States to establish special medicaid fraud control offices. The 90-percent Federal matching rate was intended to allow each State a full 3-year period to establish a unit, after which time the Federal share of funding would revert to the 50-percent Federal share paid for most medicaid administrative activities. By September 30, 1980, when the authorization period for the 90-percent Federal rate was to end, 30 States had organized fraud control offices. About two-thirds of the units, however, had not established themselves early enough to have the benefit of a full 3 years of 90-percent Federal funding and it was doubtful that they would be able to continue operations without an extension of their authorization.

A General Accounting Office (GAO) evaluation [17] of already established units concluded that the units could be effective in combating medicaid fraud and that their effectiveness should increase as more experience was gained. The units had increased States' ability to investigate and prosecute medicaid fraud with increases in the number of staff, cases handled, and convictions. The GAO felt that the anti-fraud units acted as a deterrent to attempted fraud by medicaid providers and had an impact on changing State legislation and medicaid regulations to make it easier to identify fraud and provide for more stringent penalties.

The GAO also agreed that it would be extremely difficult for the units to become self-supporting if the expanded Federal matching fund period was ended.

FEDERAL FUNDING EXTENDED

Legislation to extend the period of 90-percent Federal match funding for the State units was favorably reported by the Senate Finance Committee in 1979 (H.R. 934, December 10, 1979) and by the House Committee on Interstate and Foreign Commerce early in 1980 (H.R. 4000, April 23, 1980); however, final action still had not been taken on these bills as the end of the period for increased Federal funding drew near.[18]

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[17] U.S. General Accounting Office. "Federal Funding for State Medicaid Fraud Control Units Still Needed," report to the Congress by the Comptroller General of the United States. Washington, 1980. (HRD–18–2, Oct. 6, 1980).

[18] See U.S. Congress. Senate. Special Committee on Aging. "Developments in Aging: 1978," part 1, pp. 70–72, and "Developments in Aging: 1979," part 1, pp. 96–97, for earlier reports of hearings conducted by the Committee on Aging in July 1978 on the effectiveness of the State medicaid fraud control units and the progress of legislation to extend Federal funding for the units in 1979.

Concerned that a number of the State units would go out of existence before they had been given adequate time to establish themselves, Senators David Pryor and Frank Church of the Special Committee on Aging won Senate approval of an amendment to the Health Sciences Promotion Act of 1980 to continue authorization for 90-percent Federal funding until October 1, 1982.[19] It soon became apparent that this bill would not be passed by the full Congress and signed into law before the end of the fiscal year when authorization for the fraud units would expire. In response, Senator Lawton Chiles, chairman of the Special Committee on Aging, amended a continuing appropriations resolution to continue funding for the units.[20] The amendment provided for 90-percent Federal funding of State fraud control units until December 19, 1980.

During this period, Congress completed action on the Omnibus Reconciliation Act of 1980, signed into law on December 5, 1980 (Public Law 96–499), which authorizes Federal matching payments to any State for the costs of establishing and operating State medicaid antifraud units at a rate of 90 percent for a 3-year period and 75 percent thereafter.

At least 11 additional States are expected to establish medicaid fraud control units as a result of this action, and continued operation of the 30 existing units is guaranteed.

B. State Medicaid Management Systems

Section 901 of Public Law 96–398, signed October 7, 1980, contains an amendment sponsored by Senator Richard Schweiker which requires that all State medicaid programs must have mechanized claims processing and information retrieval systems (medicaid management information systems—MMIS) in place by September 30, 1982, in order to avoid penalties in Federal medicaid reimbursement for administrative expenses. The new law also requires the Secretary of the Department of Health and Human Services to provide to States technical assistance for system operation. Information relating to the detection of fraud and abuse in the medicaid program must be exchanged and shared with medicare program administrators.

As of October 7, 1980, 32 States and New York City had approved MMIS systems in place.

C. New Abuse Amendments

The Omnibus Reconciliation Act of 1980 (Public Law 96–499) provided for further controls against abuse in the medicare and medicaid programs. The Federal Government was given access to records of those who contract with medicare providers to supply services as well as the authority to recover overpayments to medicare providers and to bar convicted abusers from any further participation in medicare or medicaid or the title XX program of social services.

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[19] S. 988, Public Law 96–538, signed Dec. 17, 1980. See Pryor, David. Remarks in the Senate. Congressional Record, June 19, 1980: p. S7504 and Church, Frank. Remarks in the Senate. Congressional Record, June 20, 1980: p. S7631.

[20] Amendment No. 14 to H.J. Res. 610, Public Law 96–369, Oct. 1, 1980.

1. ACCESS TO CONTRACTOR RECORDS

Federal reimbursement through medicare to providers of covered services (such as home health agencies, skilled nursing facilities, hospitals, etc.) for the costs of services furnished by subcontractors will no longer be allowed unless the Secretary or the Comptroller General is given full access to the records of the subcontractor. All contracts negotiated by medicare providers must stipulate access to records for 4 years after the services are furnished. The new law applies to all contracts whose cost or value is $10,000 per year or more. The same access to records must also be provided for any further contract between a subcontractor and any other organization related to the subcontractor by common ownership or control.

Testimony taken by Senator Lawton Chiles before a Senate Special Committee on Aging hearing in late 1979 demonstrated the difficulties experienced by Federal auditors in obtaining access to the books and records of contractors.[21] Medicare funds were reimbursing for the services of management companies contracting with home health agencies for startup and continuing administrative services. Medicare auditors, however, who have the responsibility to verify a home health agency's administrative costs, had no access to the management company's cost records. Unless voluntarily given, auditors had to go through a lengthy process of administrative subpena by the Department of Health and Human Services or a grand jury subpena through the Justice Department.

An earlier General Accounting Office (GAO) report questioned the costs of a number of long-term contracts to home health agencies for administrative and consulting services.[22] GAO auditors found instances in which contracts were negotiated for 20 to 30 years. They also questioned the use of franchising arrangements in home health agency contracts, in which the home health agency agreed to pay the contractor for administrative services based on a percentage of medicare reimbursements received from the Federal Government.

Subsequent to the GAO report and the hearings before the Committee on Aging, Representative Sam Gibbons, chairman of the House Ways and Means Subcommittee on Oversight, proposed an amendment to H.R. 3990 to apply limitations on medicare reimbursement for contract services.[23] The amendment was limited to home health agency contracts and prohibited reimbursement for the costs of any contract which exceeded a term of 5 years or for which payment was based on a percentage of medicare reimbursement. It was later modified to apply to contract arrangements by all types of medicare providers.

2. EXCLUSION FROM PROGRAM PARTICIPATION

Any health professional who has been convicted of any program-related crime under medicare or medicaid will be barred from further

[21] U.S. Congress. Senate. Special Committee on Aging. "Abuse of the Medicare Home Health Program." Miami, Fla., Aug. 29, 1979, p. 12. See "Developments in Aging: 1979," part 1, pp. 94–96, for report on additional hearing findings.

[22] U.S. General Accounting Office. "Home Health Care Services—Tighter Fiscal Controls Needed," report to the Congress by the Comptroller General of the United States. Washington, 1979, (HRD–79–17, May 15, 1979).

[23] Reported to the full House by the Ways and Means Committee on Nov. 5, 1979 (H. Rept. No. 96–588, part 1) and by the House Committee on Interstate and Foreign Commerce on Mar. 18, 1980 (H. Rept. No. 96–588, part 3).

participation in these programs as well as the title XX social services program. (Examples of program-related crimes would be accepting a kickback or bribe from a supplier of services, or submitting a falsified cost report to the Federal or State government.)

Exclusions from participation under previous law did not include the title XX program and were applicable only to physicians and other practitioners. Under the new law, any health professional receiving reimbursement from medicare or medicaid, such as an administrator of a nursing home, hospital, or home health agency, who has been convicted of a crime related to either the medicare or medicaid program will no longer be able to receive any payment for services from medicare, medicaid, or title XX.

3. RECOVERY OF MEDICARE OVERPAYMENTS

The Secretary of the Department of Health and Human Services is authorized to withhold the Federal share of medicaid payments due a provider of services to recover any medicare overpayments made to that provider.

Medicare providers are paid on the basis of the costs incurred by the provider for services rendered to medicare beneficiaries, including the administrative costs of operating the nursing home, home health agency, hospital, or other type of medicare-certified agency. In the case of a facility which also receives reimbursement from other sources, medicare pays a proportionate share of the administrative costs. Medicare payments are made to the facility on the basis of a report of costs incurred during a particular time period, usually 1 year. Frequently, an estimate of the costs which will be incurred during a coming year is used to make periodic "advance" payments to the facility.

Once the end-of-the-year cost report is submitted to the medicare program, it is audited to verify that the costs claimed by the facility are allowable charges under the medicare program and that they are "reasonable" amounts for the costs of doing business and providing services. Any differences in reimbursement between the amounts paid to the provider during the year and the results of the audited cost report are then settled with the provider. Additional medicare payments can be made to the provider—or the provider can be required to repay any overpayments to the medicare program. If the provider continues to participate in medicare, overpayments can be withheld gradually from future medicare reimbursements.

In some cases, medicare providers have been able to submit inflated cost estimates during a period of providing services, and then withdraw from the medicare program—or reduce their level of participation enough so that the recovery of overpayments would not be possible. Prior to this change in the law, the Secretary could only withhold the Federal share of medicaid payments if the provider was no longer participating in the medicare program. The change allows the Secretary to extend this use of medicaid withholding under circumstances in which the provider continues to participate in medicare, but at a level too low to cover prior overpayments. It also would apply, for example, to a situation in which a physician initially accepting medi-

care assignment (agreeing to accept medicare as payment in full for services provided to medicare beneficiaries) ultimately refuses assignment.

The amendments to recover medicare overpayments and to bar convicted abusers from further program participation were introduced in the Senate by Senators Lawton Chiles, John Melcher, and David Pryor of the Committee on Aging in August 1979 (S. 1662).[24] The amendments were favorably reported by the House Ways and Means Committee on November 5, 1979, and were subsequently accepted by Senate conferees as part of the Omnibus Reconciliation Act of 1980. S. 1662, a measure to authorize the Secretary of the Department of Health and Human Services to impose civil monetary penalties for fraudulent claims for medicare or medicaid, was not acted upon.

D. Medicare Home Health Controls

Medicare's home health program is of primary importance for thousands of home-bound elderly suffering from illness and disability. The utilization of home health services has been increasing dramatically in recent years (see following box). Part of the reason for this increase is the rising proportion of older persons in the population, and part is due to a heightened awareness of the desirability of home health services on the part of physicians and other health care professionals selecting the appropriate modes of health care for their patients. A third reason is the increasing number of medicare-certified home health agencies, making services more widely available.

The Federal Government has taken an active role in increasing the number of medicare-certified home health agencies through a program of small grants for startup and development of agencies in underserved areas of the country, as well as training of home health agency personnel. This program, which is discussed more fully in chapter 4, has been responsible for the development of 344 medicare-certified home health agencies, primarily in rural areas of the country, during its 5 years of existence.

This year, Congress amended the medicare law to remove a requirement that proprietary home health agencies be licensed by a State as a condition for participation in medicare.[25] In mid-1980, only 25 States licensed proprietary home health agencies, and proprietary agencies only accounted for about 6 percent of all medicare-certified agencies. This change in law, however, will contribute to an even more rapid growth in the number of agencies participating in the medicare program.

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[24] "Medicare and Medicaid Fraud and Abuse Amendments of 1979," introduced in the Senate Aug. 2, 1979. See Chiles, Lawton. Remarks in the Senate. Congressional Record, Aug. 2, 1979; p. S11493.

[25] As part of Public Law 96–499, signed Dec. 5, 1980.

GROWTH OF THE MEDICARE HOME HEALTH PROGRAM

Total medicare reimbursement for home health services increased from $217 million in 1975 to $912 million in 1981.

Almost 16 million medicare-reimbursed home health visits were made to the elderly and disabled in 1977. Aged medicare beneficiaries account for over 90 percent of both the number of home health visits made and the medicare reimbursements to home health agencies.

The number of medicare-certified home health agencies has increased from about 2,250 in 1975 to about 3,000 in 1980.

Source: Office of Research, Demonstrations, and Statistics, Health Care Financing Administration, U.S. Department of Health and Human Services.

Until recently, very little attention has been paid to the development of this health industry within the medicare program. One reason is because home health expenditures represent so small a proportion of total medicare spending—under 2 percent. The recent growth of the home health program under medicare, however, has led to an increased focus on abuses within the program.[26] A number of amendments considered in the Senate and House in 1979 were enacted into law this year.[27]

1. BONDING AND ESCROW ACCOUNTS

The Secretary of the Department of Health and Human Services was given the authority to establish bonding and escrow requirements for home health agencies having little or no funds other than those received through medicare payments.

The Secretary could take this action in order to assure that a source of funds would be available to make repayment of medicare overpayments. Medicare would no longer reimburse home health agencies for interest on funds borrowed to repay medicare overpayments.

The amendment was in response to concerns about the rising numbers of "medicare-only" or "100-percenter" home health agencies for

[26] U.S. Congress. Senate. Special Committee on Aging: "Abuse of the Medicare Home Health Program," 1979. "Developments in Aging: 1979," part 1, pp. 94–96.

[27] Amendments attached to H.R. 3990 by Representative Sam Gibbons. Reported in the House by the Committees on Ways and Means and Interstate and Foreign Commerce. Enacted into law as part of H.R. 7765, Omnibus Reconciliation Act of 1980, Public Law 96–499, signed Dec. 5, 1980.

which medicare pays most or all administrative expenses as well as service costs. About 570 home health agencies now operate with at least 80 percent of all their funds coming from medicare. Over half of these, 335, operate with 90-percent medicare funding.

2. REGIONAL INTERMEDIARIES

The Secretary of the Department of Health and Human Services is required to establish regional intermediaries for home health agencies. This requirement, which will concentrate administration of the medicare home health benefit in a smaller number of intermediaries (private insurance companies processing and paying home health claims), is expected to lead to the development of more expertise in administering the home health program and more reliable cost and utilization information.[28] The development of viable administrative and service cost limits and performance standards for home health agencies has not been entirely successful in the past.

The Department has been working throughout the year to develop a proposal to implement this new requirement. A plan for designation of statewide intermediaries for home health agencies may be proposed early in 1981.

Changes in the medicare law regarding access to contractor records, exclusion from program participation, and recovery of medicare overpayments, discussed above, would also apply to home health agencies.

3. COST CAPS QUESTIONED

An amendment to impose a medicare cost cap on home health agency skilled nursing visits and home health aide visits, which would be no higher than an individual State's daily medicaid payment rate for skilled nursing facility services, was also considered by Congress. This proposal, as well as a proposal to limit the allowable costs for home health agency visits under medicare to the 75th percentile of audited costs, was recommended by the Senate Finance Committee as a way to reduce the overall costs of the medicare program. The amendments were rejected by conferees, however, in the final bill.[29]

The Secretary of the Department of Health and Human Services now has authority to set cost caps on home health agency per visit costs, and caps equivalent to the 80th percentile of unaudited costs are now in effect. They are adjusted upward each year to allow for inflation. The Senate Finance Committee, however, expressed concern over what it termed the "unrealistically high levels" of some home health agency per visit costs, and this concern is likely to continue.

The current average per visit cost cap in effect for freestanding home health agencies is $42.67 for a skilled nursing visit in a metropolitan area (SMSA) and $44.75 in a rural area. Average caps for home health aide visits are $32.36 in an SMSA and $31.49 in a rural

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[28] U.S. Congress. Conference Committee on Omnibus Reconciliation Act of 1980. Conference report to accompany H.R. 7765. Nov. 26, 1980. (Washington, 1980. Report No. 96–1479). See also Chiles, Lawton. Remarks in the Senate on introduction of S. 489. Congressional Record, Mar. 1, 1979 : p. S2002.

[29] U.S. Congress. Senate. Committee on Finance. "Spending Reductions : Recommendations of the Committee on Finance Required by the Reconciliation Process, the First Budget Resolution for Fiscal Year 1981." (Committee print, CP 96–36, June 25, 1980) Washington, U.S. Government Printing Office, 1980, pp. 45–47.

area.[30] These caps are in effect for the year beginning July 1, 1980. Limits are also calculated for physical and occupational therapy visits and speech pathology and medical social services. Limits for provider-based home health agencies are calculated differently than for freestanding and are somewhat higher, e.g., $54.17 for a skilled nursing visit and $47.36 for a home health aide visit. The national average daily medicaid skilled nursing facility rate during 1980 was $36.25. Medicaid skilled nursing facility rates vary widely from State to State, as services provided are not always the same. They range from about $16 per day to $55 per day.[31]

III. MENTAL HEALTH

A. Special Committee on Aging Hearings

1980 hearings by the Special Committee on Aging, entitled "Aging and Mental Health: Overcoming Barriers to Service," highlighted both the unmet mental health needs of older Americans and positive solutions to the problem.

In his opening statement at the hearing in Little Rock, Ark., on April 4, 1980, Senator David Pryor, who chaired the "Aging and Mental Health" hearings summed up the magnitude of the problem:

> Twenty-five percent of all reported suicides are committed by individuals age 60 and older, with the highest suicide rates being among men over 85.
>
> The incidence of depression, which is the most common mental illness for all ages, rises sharply for the over-65 population.
>
> Psychosis is the most severe form of mental disorder, and it is twice as prevalent in the over-75 age group as among persons age 25–34.
>
> . . . the National Institute on Aging states that 10 to 15 percent of the cases of organic brain syndrome, or senility, are reversible, with 30 percent of the cases being treatable. Yet 50 percent of the elderly in nursing homes are there because of a diagnosis of senility, and over 3 million Americans are suffering mild to severe symptoms of the condition.
>
> As alarming as these statistics may be, it is more distressing today to compare these needs with the percent of Federal dollars being allocated to mental health research and services for older Americans. Listen to this:
>
> Less than 2 percent of all medicare reimbursement is being spent on mental health care.
>
> Approximately 4 percent of the budget of the National Institute of Mental Health is being devoted to research, training, and services specifically for older Americans.
>
> Nationwide, only about 4 percent of the clients being served by community mental health centers are 65 and older, with approximately half that number receiving ongoing treatment or counseling.

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[30] Federal Register, vol. 45 No. 110, Thursday, June 5, 1980, p. 38014.
[31] Unpublished data prepared for Senate Committee on Aging by Health Care Financing Administration.

Studies have shown that even those older persons who are being served by community mental health centers received a biased range of services, for example, less individual therapy, more inpatient treatment than outpatient services, etc.

Less than 2 percent of the patients of private psychiatrists are 65 and older, and less than 7 percent of the patients of private practicing psychologists are elderly. In fact, 85 percent of the psychiatric care of older Americans is delivered in institutions.

Specialized training of professionals on the mental health needs of the elderly is insufficient today. For example, less than 100 of the 23,000 practicing psychologists in 1978 had formal training in geriatrics, and only about 400 of them were seeing older clients.

Testimony at the "Aging and Mental Health" hearings reinforced these estimations of the problem, and also supported findings of the President's Commission on Mental Health (published 1978) and the National Conference on Mental Health and the Elderly, sponsored by the House Select Committee on Aging (1979).[32]

The reasons for the failure of the current mental health system to adequately serve the elderly include the following:

—The stigma many older persons attach to seeking mental health services.

—Inadequate reimbursement for mental health services under medicare, medicaid, and other health insurance programs.

—Diagnostic failure due to a lack of differentiation between the physical and mental problems of the older patient, which is complicated by the interaction of prescription drugs the individual may be taking for chronic conditions.

—Lack of training of physical and mental health professionals in geriatrics and the special mental health problems and needs of older Americans; and

—Conscious or unconscious discrimination by mental health professionals against the elderly.

The "Aging and Mental Health" hearings focused on how these barriers to mental health care for America's aged population might be overcome. The April 4 hearing in Little Rock brought together representatives of the mental health professions, the State offices of aging and mental health, the Veterans' Administration, local community mental health centers and area agencies on aging. The witnesses explored cooperative efforts among their organizations in Arkansas that have resulted in the State having a better record for serving the elderly than the national average. The key to providing needed mental health services to older persons, according to the witnesses, lies in coordination of physical, mental health, and social services at the State and local levels, outreach to older persons in nonstigmatized settings, differential diagnosis to identify the physical and mental problems facing the elderly patient, and adequate training of personnel in both aging and mental health.

[32] For a further discussion of these findings, see "Developments in Aging: 1978," part 1, pp. 58–60, and "Developments in Aging: 1979," part 1, pp. 59–61.

Senator Pryor chaired the second in the series of "Aging and Mental Health" hearings in Washington on May 22. The hearing continued the theme of coordination among physical, mental health, and social services by inviting witnesses from the Administration on Aging, the National Institute on Mental Health, the Veterans' Administration, and private organizations representing various aging and mental health groups. Just as the Arkansas hearing focused on coordinating efforts at the State and local levels, the hearing in Washington sought to identify collaborative activities among agencies and organizations at the national level aimed at overcoming barriers the elderly face in obtaining mental health services. Witnesses gave particular emphasis to how community mental health programs, due for reauthorization in 1980, might be improved, as well as discussing needed changes in the medicare reimbursement system.

B. The Mental Health Systems Act

The 1980 session of Congress reauthorized and expanded community mental health programs by enacting the Mental Health Systems Act (Public Law 96–398), which was signed by the President on October 1, 1980. The final version of the legislation retained the emphasis on underserved populations which had been the main focus of the bill introduced by Senator Kennedy on behalf of the administration in 1979 (S. 1177). Based on the recommendations of the President's Commission on Mental Health, S. 1177 sought to encourage community mental health centers and other public and private nonprofit entities to meet the mental health needs of underserved populations, including the chronically mentally ill, the elderly, severely disturbed adolescents and children, and others.

As reported by the Senate Labor and Human Resources Committee on May 15, 1980 (S. Rept. 96–712), S. 1177 authorized a Federal-State-local partnership in the delivery of mental health services (title I). The legislation established a series of competitive grants to local, public, or private nonprofit agencies of State agencies to provide services to underserved, or priority population groups, including the elderly and the chronically mentally ill, or to undertake prevention activities or linkage among physical and mental health services (title II). It also mandated a bill of rights for mentally handicapped persons (title III).

The provisions in title II for the chronically mentally ill and the elderly were of particular interest to the aging community. The special grants for services for the chronically mentally ill could be awarded to a public or private nonprofit entity, which would agree to provide either identification of the target population and assessment of needs, case management, or support services. When the Health Subcommittee of the Senate Labor and Human Resources Committee was considering the Mental Health Systems Act, S. 1177, Senator Richard Schweiker amended the bill to include a new grant section to provide mental health services for elderly individuals. The special grants for services for the elderly could be awarded to entities which agree to provide outreach and at least one of the following:

—Identification and assessment of needs of the elderly and services not currently being provided.

—Assuring the availability of appropriately trained personnel.
—Coordination of mental health and support services with services available through related Federal programs, such as the Older Americans Act, title XX, medicare, medicaid, etc.
—Providing mental health services to the elderly in nursing homes, intermediate care facilities, boarding homes, senior centers, etc.; or
—Differential diagnosis for elderly individuals to distinguish between their medical and mental health needs.

Each of the sections for special service grants provided that the State could apply to be the sole contractor for services, and requirements for States selecting this option were delineated. Elderly individuals could also benefit from the provisions for prevention activities and linkage between physical and mental health care.

1. SENATE COMMITTEE ON AGING AMENDMENTS

S. 1177 came before the Senate on July 24. Senator Pryor offered a series of amendments which were cosponsored by members of the Special Committee on Aging, including Senators Chiles, Glenn, Burdick, Domenici, and Heinz. Based on testimony of the "Aging and Mental Health" hearings, the amendments sought to insure that a comprehensive range of essential services would be provided for the elderly under the new grants for special services. The first amendment required applicants for the contracts to serve the chronically mentally ill to provide all three of the services identified as essential to their successful entry into the community—identification and assessment, case management, and community support services. The second established a priority among the services to the elderly by requiring grantees to provide not only outreach, but also differential diagnoses and either services not currently being provided or services in settings where the elderly reside—nursing homes, intermediate care facilities, senior centers, etc. The provisions for coordination of mental health and support services with related Federal programs and management to assure appropriately trained personnel were retained as options for grantees, particularly in areas where the basic core of services were being provided.

Two of Senator Pryor's amendments focused on the training needs of mental health professionals to serve the elderly and other priority population groups. The final amendment gave the State mental health agency, in cases where the State elected to be the sole contractor for mental health services, the responsibility for certifying that standards for boarding homes are being enforced. All of the amendments were unanimously adopted.

In further floor action on S. 1177, the Senate adopted a compromise substitute to the bill of rights and advocacy provisions of the bill. The amendment, offered by Senator Robert Morgan, replaced the extensive requirements for States to establish specific programs for rights of mental patients and grievance procedures and suggested a model for State bills of rights and advocacy.

2. HOUSE ACTION

The House of Representatives in 1980 proceeded with a more limited extension of community mental health programs than encompassed by by the Senate-passed bill or proposed by the administration. H.R. 7299, reported by the Interstate and Foreign Commerce Committee on May 15 (H. Rept. 96–977), provided for special grants for services to the chronically mentally ill, severely disturbed adolescents and children, Indian tribes or organizations, services in ambulatory health care centers, and for innovative projects, but it included no separate provisions for grants to the aged. Instead, the elderly were included in the section for services to priority population groups. The committee contended that older Americans would be adequately served as one of the priority population groups and by the provisions for ambulatory health care centers.

3. FINAL PROVISIONS OF PUBLIC LAW 96–398

In the House-Senate conference (Conf. Rept. 96–1367), the emphasis on special services for the elderly was retained. As signed into law on October 7 (Public Law 96–398), the Mental Health Systems Act contained the following provisions of potential benefit to the elderly:

—Grants may be made to any State mental health authority, community mental health center, or public or private nonprofit entity which provides identification of the chronically mentally ill; assistance to such persons in gaining access to essential mental health, medical, and social services; case management; and coordination of services to the chronically mentally ill (section 202).

—Grants may be made to any public or private nonprofit agency which provides at least the following services: Locating elderly individuals in need of mental health services; medical differential diagnosis; the specification of mental health needs of the elderly and the mental health and support services designed to meet these needs; services to the elderly in the community or services to older persons in nursing homes and intermediate care facilities, and staff training in such facilities (section 204). The law provides, however, that in areas where there is a community mental health center, the grants are restricted to the CMHC or the State agency.

—Grants may be made to any public or private nonprofit agency which has an affiliation with a health care center and provides mental health services which include at least 24-hour emergency services, outpatient services, consultation and education (section 206).

—Grants may be provided to any public or private nonprofit entity for projects for prevention of mental illness and promotion of mental health and to demonstrate the effectiveness of intervention techniques (section 208).

The final version of the legislation also retained provisions to encourage States to adopt a bill of rights and advocacy programs for mental patients, although like the Senate-passed version, there are no

Federal mandates or sanctions for States which do not establish and guarantee the rights of the mentally ill (title V).

C. Medicare Reimbursement for Mental Health Services

A wide range of proposals for expansion of mental health benefits under medicare was introduced in the 96th Congress. Although the House of Representatives attempted to remove restrictions in current medicare coverage of mental health, the 1980 session ended without congressional enactment of amendments to the medicare law relating to mental health services.

The importance of adequate medicare reimbursement for mental illness was stressed by Senator Heinz in his remarks before the Senate on July 24, 1980, during consideration of the Mental Health Systems Act.

> . . . the services that this bill (S. 1177) would provide and the amendments that Senators Pryor, Chiles, myself, and other members of the Aging Committee have offered today are vital steps toward providing the critically based outpatient care for our needy older Americans. But more must be done to remedy the fragmented, acute-care oriented Federal health care delivery system that is inadvertently, and unintentionally assuring that millions of our elderly do not receive the care needed to allow them to be productive, active participants in our society.
>
> The present medicare and medicaid systems stress treatment for acute disorders, whereas the elderly suffer from chronic disorders related to longevity. I believe it is time our medicare system be revitalized to serve the purpose for which it was intended—that is, meeting the health care needs of the elderly and the disabled.

1. EARLY PROPOSALS

Some of the bills introduced during the 96th Congress to expand medicare coverage for mental health services include:

—S. 123, introduced by Senator Inouye, which would have licensed psychologists to be providers for purposes of medicare reimbursement.

—S. 458, sponsored by Senator Stafford, designed to establish provider status for community mental health centers, partial hospitalization in lieu of inpatient hospitalization up to 60 days per year, and provide reimbursement up to 25 visits per year for outpatient services by community mental health centers.

—S. 1289, authored by Senator Heinz, would have eliminated the 190-day lifetime limit for inpatient psychiatric care under part A of medicare, replaced the current 50–50 percent copayment for outpatient mental health services under medicare part B with 80–20 percent copayment (the standard for physical health services), eliminated the $250 annual ceiling for part B outpatient mental health services, extended provider status to qualified community mental health centers, provided for reimbursement of

services by CMHC's on a cost-related basis, and allowed coverage of partial hospitalization by CMHC's.

—S. 2176, introduced by Senator Inouye, would have included social workers as qualified providers under medicare.

—S. 3029, introduced by Senators Matsunaga and Inouye, took a different approach from the aforementioned bills on the issue of expanded medicare coverage for mental health. This legislation would have authorized the creation of a National Professional Mental Health Services Commission, comprised of 13 Presidential appointees, to represent the various mental health professions—psychiatrists, psychologists, clinical social workers, and psychiatric nurse specialists. The Commission would have been charged with evaluating and recommending to the Secretary of Health and Human Services combinations of patient characteristics, therapeutic techniques, mental health professionals, and treatment settings which are safe, effective, and appropriate for specific mental health problems. Had the bill been enacted, medicare reimbursement would have ceased after 1980 for any mental health service rejected by the Commission in concurrence with the Secretary. Beginning in 1984, medicare payment could have been made only for those services approved, for reimbursement. The bill also would have raised the annual limitation for covered outpatient services from $250 to $1,000 and reduced the beneficiary copayment for mental health services from 50–50 percent to 80–20 percent.

2. NO FINAL ACTION

The 96th Congress adjourned without hearings by the Senate Finance Committee or Senate action on any of these legislative measures. The House, however, did take steps toward expansion of medicare benefits for mental health services. The medicare amendments (H.R. 3990) reported by the House Ways and Means Committee on November 5, 1979 (H. Rept. 96–588, pt. 1) and by the Interstate and Foreign Commerce Committee on March 18, 1980 (H. Rept. 96–588, pt. 3), contained the following provisions for extension of medicare coverage for mental illness:

—The ceiling on reimbursement of outpatient mental health services was raised from $250 to $750 per year.

—The beneficiary copayment was reduced from 50 to 20 percent for outpatient mental health services, the same amount used for physical health services.

—Payment was authorized for services performed by qualified psychologists; and

—Cost-related or other reasonable reimbursement was authorized for services provided by qualified community mental health centers.

Although the 96th Congress did not take up either the House (H.R. 3990) or Senate (H.R. 934) versions of the medicare amendments, provisions for changes in the medicare program were incorporated in recommendations by the House Ways and Means Committee (H. Rept. 96–1150, part 1) and the Interstate and Foreign Commerce Committee

(CP 96–IFC 51) for spending reductions in the omnibus budget reconciliation bill (H.R. 7765). The Senate Finance Committee reported only the savings portions of its version of the medicare amendments, and H.R. 934 contained no provisions for expanding medicare mental health coverage. In conference, most of the spending provisions of the House bill were dropped, including the coverage increases for mental illness under medicare (Conf. Rept. 96–1479).

D. Outlook for 1981

Mental health will be a significant issue in the 1981 White House Conference on Aging. Consideration of issues such as long-term care and health promotion and disease prevention will include discussion of the chronically mentally ill and activities to promote mental health among older persons in the community setting. In preparation for the Conference, a Miniconference on Mental Health of Older Americans was held in San Diego, Calif., on November 17–19, 1980, by the American Psychiatric Association, the American Psychological Association, the American Nurses' Association, and the National Association of Social Workers. Recommendations by these organizations have been submitted to a technical advisory committee for the White House Conference and will be distributed to the delegates at regional and national meetings of the Conference.

During 1980, the Department of Health and Human Services developed a national plan for the chronically mentally ill. The task force developing the plan was comprised of representatives of all parts of the Department related to mental health services and reimbursement, including the Health Care Financing Administration, the National Institute on Mental Health, the National Institute on Aging, etc. The final draft of the recommendations were submitted to the Secretary in September. Whether these strategies or new ones proposed by the Reagan administration are pursued, the issue of the chronically mentally ill and deinstitutionalization will remain important in the coming years.

Continued focus on medicare reimbursement for mental health services can be expected in the 97th Congress. Although it is hard to predict whether the new Congress will consider actual expansions in coverage, or support legislation designed to evaluate the safety and effectiveness of mental health services, the cost of program expansions will be an important issue.

Chapter 4

LONG-TERM CARE ISSUES

CHAPTER HIGHLIGHTS

Few concrete actions were taken during 1980 to develop a comprehensive statement of Federal policy toward long-term care services for the elderly and disabled, but the incremental development of community-based and home care services continued. Amendments to liberalize the medicare home health program were signed into law and new bills to broaden home care services were introduced. Grants and contracts were awarded to a number of States to conduct new "channeling" demonstrations and develop State long-term care plans.

New questions were raised about the future of Federal nursing home policies, as budget pressures halted the development of Federal rules to expand nursing home resident's rights and require comprehensive patient care management in all federally funded nursing homes. Congress also approved a controversial amendment to repeal Federal requirements for State medicaid nursing home payments.

Preparations for long-term care policy discussions during the 1981 White House Conference on Aging also reflected a growing concern about Federal budget pressures, with little room for significant expansion of direct Federal funding for long-term care services. Participants in a number of long-term care forums indicated their belief that State and local governments, as well as private voluntary efforts, will be faced with many challenges in the years ahead.

I. CAPACITY BUILDING: EXPANDING AND DELIVERING COMMUNITY-BASED SERVICES

Amendments to expand medicare home health services were signed into law at the end of 1980 and new bills were introduced which, if enacted, would increase the supply of community and in-home services. Efforts to improve the long-term care data base through additional research and to develop education and training opportunities for service providers were also underway.

Discussed below are a number of initiatives which have either begun during this past year or will be the subject of further congressional consideration during 1981. Other capacity-building activities in long-term care (ongoing Health Care Financing Administration (HCFA) and Administration on Aging (AoA) demonstrations, HCFA medicare-waiver hospice care projects, and AoA programs with local health planning agencies, for example) are discussed in part 2 of this report, report of the Department of Health and Human Services.

Impact of 1978 Amendments

Amendments to the Older Americans Act in 1978 [1] authorized special demonstration activities to assist State and local governments in the development of comprehensive long-term care service programs for the elderly. The 1978 amendments also required increased coordination of all activities of the Administration on Aging and the network of State and area agencies on aging with programs and activities of the HCFA (which administers the medicare and medicaid programs) and Federal, State, and local health planning systems.

In fiscal year 1980, Congress appropriated $20.5 million to fund a series of capacity-building activities in long-term care, with primary emphasis to be given to the development and testing of new models of comprehensive community long-term care programs.[2] Activities were to be jointly funded through AoA and HCFA, with a $10-million allotment from AoA by special authorization and $10.5 million to be obligated through the HCFA overall research and demonstration authority. The office of the Assistant Secretary for Planning and Evaluation was to assure that all efforts were coordinated throughout the Department.

In June 1980, the Department notified the Committee on Aging [3] of its intent to obligate up to $14 million of earmarked appropriations to support and evaluate a series of long-term care "channeling" demonstrations; approximately $1.5 million to support 1-year State system development grants for statewide long-term care plans; and $3 million for national surveys to gather new information on the characteristics of the long-term care population, services currently available to them, and estimates of further needs. Additional amounts from the appropriation would be directed toward continuing current long-term care demonstration projects within HCFA and AoA.

The administration's budget request for fiscal year 1981 for this special long-term care initiative, as submitted to Congress in January 1980, was for $20.5 million to continue existing initiatives, and fund up to 10 additional channeling demonstrations.[4] In a revised budget submitted by the administration later in the year, however, the amount requested for the long-term care activities was reduced to $15.5 million.[5] The full $15.5 million was approved by Congress as part of a continuing appropriations bill for fiscal year 1981.[6] In a colloquy on the Senate floor during debate on the continuing resolution, Senator Lawton Chiles noted the Senate Appropriations Committee intent that priority continue to be given to the long-term care demonstrations, and pointed to the "unique coordination and cooperation they are forging between health programs funded under medicare and

[1] Public Law 95–478.
[2] Public Law 96–38. See U.S. Congress. Senate. Appropriations Committee. "Authorizing Appropriations for the Departments of Labor, Health and Human Services," fiscal year 1980. Washington, S. Rept. No. 96–247, p. 149.
[3] Letter to Senator Lawton Chiles, chairman, Senate Special Committee on Aging, from John Palmer, Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, June 3, 1980.
[4] The Budget of the U.S. Government, fiscal year 1981. Executive Office of the President, Office of Management and Budget, Washington, 1980.
[5] Fiscal Year 1981 Budget Revisions. March 1980. Executive Office of the President, Office of Management and Budget, Washington, 1980.
[6] H.J. Res. 637, Public Law 96–536. The continuing resolution, however, is only effective through June 5, 1981.

medicaid and social services supported by title XX of the Social Security Act and the Older Americans Act."[7]

The administration's budget request for fiscal year 1982 asked for an appropriation of $10.5 million for HCFA and $10 million for AoA to restore the joint demonstration initiative to the original $20.5 million level.[8]

A. First Channeling Demonstration Contracts Awarded

In September 1980, the Department of Health and Human Services awarded a total of $10.4 million to 12 States to establish demonstration projects in local communities to plan and provide comprehensive long-term care services. Each project is now in the process of developing a system to screen potential recipients of long-term care services, make an assessment of each person's service needs, develop an individually tailored plan of care, make arrangements for the appropriate support services, and provide followthrough and advocacy services to each individual.

States receiving the initial demonstration awards are funded for a period of 2 years under the contracts negotiated in fiscal year 1980. An additional 3 years of funding could be received under the demonstration program design. States included in the initial round of funding were Florida, Hawaii, Kentucky, Maine, Maryland, Massachusetts, Missouri, New Jersey, New York, Ohio, Pennsylvania and Texas.

B. State System Development Grants

A total of $1.5 million in 1-year grants was awarded to 15 additional States to develop statewide long-term care plans. These States will be able to participate in the demonstration program next year, or later if the demonstrations are continued.

States receiving 1-year grants for developing State long-term care plans from fiscal year 1980 funds include California, Delaware, Illinois, Idaho, Colorado, Washington, Oregon, Minnesota, Rhode Island, Wisconsin, Arkansas, South Dakota, North Carolina, New Hampshire, and the District of Columbia.

In both the channeling demonstration contracts and the 1-year State system development grants, the Department required that administration be through a State-level agency or unit of government. Each State's Governor was to designate a single State unit to assume responsibility for administering the contract or grant, but the project had to be developed by a consortium of each State's agency with responsibility for medicaid, title XX social services, and Older Americans Act programs.[9]

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[7] Chiles, Lawton. "Long-Term Care Demonstrations." Remarks in the Senate. Congressional Record, Dec. 10, 1980, p. S16093.

[8] Budget of the U.S. Government, Fiscal Year 1982. Executive Office of the President, Office of Management and Budget, Washington, 1981.

[9] "Revised Notice of Intent To Initiate National Long-Term Care Channeling Demonstration Program," Federal Register, vol. 45, No. 57, Friday, Mar. 21, 1980, p. 18483. "National Channeling Demonstration Program: Announcement for Long-Term Care System Development Grants," Federal Register, vol. 45, No. 100, Wednesday, May 21, 1980, p. 34250.

C. Robert Wood Johnson Foundation Grants

The Robert Wood Johnson Foundation, a private philanthropic organization with a strong emphasis on research and development activities in the delivery of health care services, has also made the development of coordinated systems of community services for the elderly a priority. In February 1980, the Foundation announced the award of $4.6 million in grants to eight area agencies on aging to coordinate community services for the elderly. Each of the eight grant awards will be administered through a coordinating agency created by an area agency on aging and a community voluntary organization providing services to the elderly. The coordinating agencies will provide case-finding, assessment, referral, and followup services. Grants were made to develop local programs in New York, Ohio, Nebraska, Maryland, South Carolina, Pennsylvania, Tennessee, and Illinois.

D. Home Health Demonstration Program

Since fiscal year 1976, a special home health demonstration program, administered by the Public Health Service, has awarded 345 grants to develop 85 new home health agencies and expand services in 260 additional home health agencies. An additional 77 grants have been awarded to train home health agency personnel.

The purpose of the program, as authorized by Congress,[10] is to provide seed money for development of home health agencies in underserved areas of the country, and expand the services of other home health agencies so that they may be certified for medicare participation. To be certified for medicare reimbursement for home health services, a home health agency must provide skilled nursing services and one additional skilled service—either physical or speech therapy. Though not required for medicare participation, it is desirable to have additional services, such as home health aide services, available through a home health agency. In some areas of the country, particularly rural areas, the supply of trained professionals in all these areas is limited. Therefore, the program also authorizes special training grants.

All but 1 of the 345 home health agencies receiving grants under this program were eventually certified by medicare and continue to provide services even though Federal grant support has been terminated.

If this grant program is to continue beyond this year, it will have to be reauthorized by Congress during 1981.[11] During fiscal year 1980

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[10] The program was originally authorized by Public Law 94–66, through an amendment offered by then chairman of the Committee on Aging, Senator Frank Church, with an authorization of $8 million for demonstration and expansion grants. Public Law 94–640 extended the authorization through fiscal year 1977 with authorized levels of $8 million for demonstration and expansion grants and $4 million for training of home health personnel. An additional $12 million for fiscal year 1978 was authorized by the Health Assistance Programs Extension Act of 1977. Public Law 95–626 then authorized the program for an additional 3 years, through fiscal year 1981, incrementally increasing the authorization amounts to $13 million for demonstration and expansion grants and $2.5 million for training grants in fiscal year 1981.

[11] Senator Orrin Hatch, the new chairman of the Senate Labor and Human Resources Committee which has jurisdiction over this program, introduced a bill to reauthorize the demonstration program early in 1981 (S. 234). One major difference in the bill as introduced and the current program is that loans would be made available to proprietary home health agencies as well as grants to public and nonprofit agencies. The current program is limited to grants to public and private nonprofit agencies.

and fiscal year 1981, the administration requested no funds for the demonstration program, recommending its termination. Congress, however, continued appropriations for the program at a level of $5 million in fiscal year 1980, and $4 million for fiscal year 1981.[12]

E. Long-Term Care Gerontology Centers

During fiscal year 1979, the Administration on Aging awarded 22 grants to research institutes and universities to plan the development of long-term care gerontology centers. An additional seven planning grants were awarded during fiscal year 1980.

Once operational, a center would be a resource for educating and training professionals, paraprofessionals, and volunteers in long-term care programs and would provide assistance to States and communities to plan, manage, and set service priorities for the functionally impaired elderly.

Operational grants have been awarded to Brown University, Columbia University, the University of Southern Florida, the University of California at Los Angeles, and the University of Washington at Seattle. In January 1981, AoA announced the availability of up to $2.1 million to support up to five additional operational long-term care gerontology centers in fiscal year 1981, and $850,000 for support of two additional centers in fiscal year 1982.[13] These centers will be chosen from among those who earlier had received planning grants.

F. Medicare Home Health Amendments Signed Into Law

A number of amendments to expand the medicare home health program were signed into law on December 5, 1980.[14] Each will become effective July 1, 1981.

1. Removal of prior 3-day hospitalization requirement

A medicare beneficiary will no longer have to be hospitalized for a period of at least 3 days before becoming eligible for home health benefits under medicare part A (hospital insurance). Under the new law, the part A home health benefit will be available, essentially, under the same conditions as the part B (supplementary medical insurance) home health benefit.

The change primarily will affect about 1.1 million medicare beneficiaries who do not have medicare coverage under part B, and who would have had no access to home health coverage unless hospitalized. (The prior law required the condition for which home health was being prescribed by a physician to be the same condition treated in

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[12] The fiscal year 1981 funding is contained in Public Law 96–536, a continuing appropriations resolution passed by Congress on Dec. 16, 1980. The resolution, however, only authorizes appropriations through June 5, 1981.

[13] "Multidisciplinary Centers of Gerontology Program: Long-Term Care Gerontology Centers," Federal Register, vol. 46, No. 12, Monday, Jan. 19, 1981, p. 5072.

[14] Public Law 96–499. H.R. 7765, Omnibus Reconciliation Act of 1980. A number of amendments were originally introduced in the Senate on Feb. 26, 1979, as part of S. 489, Medicare Home Health Amendments of 1979, and some were reported by the Senate Finance Committee as part of H.R. 934 on Dec. 10, 1979. The amendments were introduced in the House and reported by the Ways and Means Committee as part of H.R. 3990 on Nov. 5, 1979. See "Developments in Aging: 1979," part 1, pp. 85–86, for discussion of original differences between Senate and House versions of the amendments.

the hospital. This will no longer apply.) The change in law is also expected to correct the potential for physicians to place a medicare beneficiary in an acute-care hospital in order to qualify the beneficiary for the home health benefit, thereby actually increasing the overall medicare costs for treatment of an illness.

2. ELIMINATION OF NUMBER-OF-VISIT RESTRICTIONS

Statutory limitations on the number of home health visits allowed under medicare part A and part B were removed. Before this change, the medicare part A home health benefit was limited to 100 visits per period of illness, and the part B benefit was limited to 100 visits per calendar year. Some medicare beneficiaries who had used up 100 visits under part A might have been able to continue receiving visits under part B, but this limitation also restricted the number of visits for those beneficiaries who did not carry part B insurance (1.1 million).

This change also was advocated to encourage more reliance on home health care as an alternative to other forms of health care.

3. REMOVAL OF $60 DEDUCTIBLE UNDER PART B

Requirements for the beneficiary payment of a $60 deductible, per calendar year, for home health services under medicare part B have been removed. With this change in the law, there is no patient cost-sharing for home health services under part B. Any medicare beneficiary utilizing other part B insurance benefits, however, still would have to meet the $60 deductible each calendar year, as well as a 20 percent coinsurance charge for each service.

4. OCCUPATIONAL THERAPY

Occupational therapy has been made a primary, or qualifying service under the medicare home health benefit. Prior to this change in the law, a medicare beneficiary had to have a prescribed need for skilled nursing care, physical therapy, or speech therapy, to qualify for the home health benefit. Occupational therapy services also were covered, but a beneficiary would have to have an additional need for one of the other three services to receive any occupational therapy. Under the new law, a prescribed need for occupational therapy alone would qualify a medicare beneficiary for the home health benefit.

This change adds more flexibility to the home health program, and is expected to effect primarily certain patients, such as stroke victims or those with vision problems, who do not necessarily need skilled nursing care but could remain in their homes with some help in adjusting to their new physical limitations. It also would mean that a recovering stroke victim, for example, who might be receiving both skilled nursing care and occupational therapy under the home health benefit, could continue to receive the occupational therapy services, if needed, after skilled nursing care was no longer needed.

5. NO STATE LICENSING REQUIRED FOR PROPRIETARY AGENCIES

The new law also eliminates the State licensing requirement for proprietary home health agencies. Prior to this change, a proprietary

home health agency was required to be licensed by a State before being able to participate in the medicare program. Public and private nonprofit home health agencies, however, did not have to be licensed by a State in order to participate in medicare if they met the medicare conditions of participation for home health agencies.

Under the new law, any home health agency, regardless of sponsorship or tax status, must be licensed by any State which has a licensing program for home health agencies if it meets the requirements of the State licensing program. In those States without licensing programs, any agency, regardless of sponsorship or tax status, meeting medicare conditions of participation, could participate in the medicare program.

This change in law is expected to increase the number of medicare-certified home health agencies throughout the country. Currently, 26 States license home health agencies. One of these States, New York, excludes proprietary home health agencies from licensure. The growth of home health agencies could also be controlled by State certificate-of-need laws. Approximately 32 States currently have some form of certificate-of-need requirement for all or some types of home health agencies.

Each of the amendments discussed above is expected to expand the availability of home health services under the medicare program. Concerns about adequate program controls, however, also resulted in changes to the law to increase program administrative efficiency and safeguards against program abuse. These amendments, and their effect on medicare home health agencies, are discussed in chapter 3, section II, "Continued Emphasis on Controls for Medicare-Medicaid Abuse."

G. Home Health Aide Demonstrations

Public Law 96–499 also contained an amendment to require the Department of Health and Human Services to conduct demonstration projects, in up to 12 States,[15] to train and employ individuals participating in the program of aid to families with dependent children (AFDC) as home health aides. The demonstration program would be administered through a State medicaid agency, and Federal reimbursement for the costs of the program would be at a matching rate of 90 percent. Programs could be operated for a period of up to 4 years. A formal training program for the aides would have to be established by any State participating in the demonstrations, and approved by the Secretary of the Department of Health and Human Services.

House and Senate conferees urged quick implementation of these demonstration programs, asking that the administration issue any necessary guidelines to States by April 1, 1981. Guidelines are being developed by the Office of Research, Demonstrations, and Statistics of the Health Care Financing Administration.

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[15] The conference report accompanying this legislation made it clear that the conferees would be amenable to any request by the administration to increase the number of States participating in such demonstrations if early experience was favorable. The report also cited seven States (California, Georgia, Hawaii, Michigan, New Jersey, New Mexico, and New York) which had already "demonstrated an active interest and support" for this type of program. U.S. Congress. House of Representatives. "Conference Report To Accompany H.R. 7765, Omnibus Reconciliation Act of 1980." Washington, report No. 96–1479, p. 144.

H. House and Senate Hearings on New Bills

In addition to completing action on home health amendments, hearings were held on two new bills which would provide different approaches to expanding the supply of community and home care services for the long-term care population.

1. NONINSTITUTIONAL LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED ACT

In June, Senators Packwood and Bradley introduced the Noninstitutional Long-Term Care Services for the Elderly and Disabled Act.[16] As introduced, the bill would create a new title XXI of the Social Security Act to provide basic entitlements for home health, homemaker, home health aide, adult day care, and respite care services. The bill also would provide for a tax credit of $100 per year for families caring for dependent elderly relatives.

Existing sources of funding for these services currently authorized under medicare (title XVIII of the Social Security Act), medicaid (title XIX of the Social Security Act), and block grants to States for social services (title XX of the Social Security Act) would become part of the new title XXI.[17]

Full reimbursement would be provided for up to 50 home health, homemaker/home health aide, and adult day care visits in any calendar year. An unlimited number of additional visits for each of these services would also be covered, but subject to a copayment adjusted according to beneficiary income. Up to 336 hours of respite care visits in the home would be available per calendar year. Adult day services could be provided in a senior center, intermediate care nursing facility, hospital, rehabilitation center, or center for the handicapped.

All individuals age 65 or over, and all disabled individuals who currently qualify for benefits under the disability insurance provisions of the Social Security Act (title II) or for supplemental security income benefits (title XVI), or medicare and medicaid would be eligible for the home and community care services.

The actual receipt of services would have to be authorized by a preadmission screening and assessment team, under the general direction of a physician. The teams would assess health and functional status, develop a plan of care, periodically reassess status, and assist the beneficiary in obtaining appropriate services from community providers.

Implementation of the new program would first be through 10 3-year statewide demonstrations (1 in each of 10 Federal Department of Health and Human Services regions) with a joint evaluation of the demonstrations by the General Accounting Office (GAO) and the Department of Health and Human Services. The bill provides that the results of this evaluation, as well as an analysis of the costs of

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[16] S. 2809, introduced on June 10, 1980. Cosponsored by Senators Nelson, Heinz, Matsunaga, Cohen, Cochran, Javits, Williams, Melcher, Domenici, Randolph, Durkin, and Leahy. See Packwood, Robert. "Long-Term Health Care for Our Senior and Disabled Citizens." Remarks in the Senate. Congressional Record, June 11, 1980, p. S6645. Bradley, Bill. "Long-Term Home Care Act of 1980." Remarks in the Senate. Congressional Record, June 13, 1980, p. S6905.

[17] See p. 86 for estimates of current Federal funding for home care services now coming from these programs.

such a program done by the Congressional Budget Office, would be required before the program could be implemented.

Hearings on the bill were conducted on August 27, 1980, by the Senate Finance Subcommittee on Health, which has jurisdiction over the measure, but no action was taken by the committee at the end of the 96th Congress.[18] It is expected that the bill will be reintroduced in 1981 for consideration by the 97th Congress.

The Senate Committee on Aging and the Committee on Labor and Human Resources also conducted a joint hearing on the bill, cochaired by Committee on Aging Senator Bill Bradley and the then-chairman of the Committee on Labor and Human Resources, Senator Harrison A. Williams.[19]

At Senate Finance Committee hearings on the bill, Senator Robert Packwood explained the reasons for combining home care funding under medicare and medicaid into a new title XXI:

> The current health care system often places people into specific entitlement groups. Those eligible for medicare are one entitlement group, those who qualify for medicaid represent another, and those eligible for title XX are yet another. While it is true that there may be limited overlap among the different entitlement programs, for the most part what we have established is a social and medical care system for the elderly and disabled that separates people by age or income class. Therefore, while persons 65 and over are eligible for both medicare and medicaid, only very low-income seniors can qualify for medicaid, and thus benefit from both programs.[20]

Senator Bill Bradley outlined three goals he expected the legislation would achieve if passed:

> . . . (The bill would) increase the availability of services and stimulate additional groups in the community to provide title XXI services by extending Federal reimbursement to community-based providers: assure a continuum of services available to the elderly and disabled under the Social Security Act by combining these services under one title and providing for service delivery on a comprehensive basis, and secure needed care for the elderly and disabled and also prevent the unnecessary and inappropriate placement of these individuals in institutions by funding screening, assessment, and case management services.[21]

2. MEDICAID COMMUNITY CARE ACT OF 1980

On December 19, 1979, Representatives Claude Pepper, chairman of the House Select Committee on Aging, and Henry Waxman, chairman of the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, introduced the Med-

[18] U.S. Congress. Senate. Subcommittee on Health of the Committee on Finance. "Comprehensive Community Based Noninstitutional Long-Term Care for the Elderly and Disabled." Hearing. 96th Congress. 2d session. on S. 2809. Aug. 27, 1980. Washington D.C., U.S. Government Printing Office. 1980. Ser. No. 96–98.

[19] U.S. Congress. Senate. Special Committee on Aging and Committee on Labor and Human Resources. "Home Health Care: Future Policy." Joint hearing. Nov. 23. 1980. Princeton, N.J. Hearing transcript not in print at time of publication of this report.

[20] Senate Finance Committee hearings, Aug. 27, 1980.

[21] Ibid.

icaid Community Care Act of 1980 (H.R. 6194). The Subcommittee on Health and the Environment, which has jurisdiction over the medicaid program in the House of Representatives, held 2 days of hearings on the bill during the year, but final action was not taken by the committee.[22] This bill is also expected to be reintroduced during the next session of Congress.

As introduced, the bill would increase the Federal medicaid matching rate to States by 25 percent (up to a maximum Federal rate of 90 percent) for community- and home-based services provided to individuals at risk of institutionalization under a State medicaid program.

In order to receive the increased match rate for these services, a State medicaid plan would be required to:

—Provide a comprehensive medical and social assessment for each person who may require nursing home care.

—Provide skilled nursing and home health aide services, medical supplies and equipment, physical, occupational, and speech therapy, adult day health services, respite care, homemaker services, and nutrition counseling as part of the medicaid home health program.

—Provide payment for these services within limits set by the Department of Health and Human Services at a rate not to exceed the cost of skilled nursing care in each State; and

—Coordinate medicaid home health services with similar services provided under medicare, title XX, and the Older Americans Act.

The bill would also allow medicaid reimbursement for home health services for the aged, blind, and disabled with incomes slightly higher than a State's medicaid income eligibility level who would nevertheless qualify for medicaid nursing home payments in that State (those with incomes between 100 and 300 percent of the Federal supplemental security income standard). This provision would primarily affect those 17 States without a "medically needy" medicaid program, and would allow them to slightly expand medicaid eligibility for home health services without having to institute a full medically needy program for all medicaid-covered services.[23]

Under current medicaid law, State home health plans vary widely. Medicaid home health services must be made available to anyone entitled to skilled nursing facility services under a State medicaid plan. A nursing service, as defined by State nurse practice statutes, must be included in a medicaid home health program. Part-time or intermittent visits by a registered nurse, home health aide services and needed medical supplies, equipment, and appliances, must also be covered. All additional services which would be required under the Medicaid Community Care Act of 1980 are at State option. Under current law, States also have much more flexibility to set payment rates for home health services.

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[22] U.S. Congress. House of Representatives. Subcommittee on Health and the Environment of the Committee on Interstate and Foreign Commerce. "Medicaid Community Care Act of 1980." Hearings. 96th Cong., 2d sess., on H.R. 6194. June 10 and 23, 1980. Washington, U.S. Government Printing Office, 1980. Ser. No. 96–165.

[23] This provision to "equalize" medicaid income eligibility levels for both nursing home care and community care was also included in the administration's legislative proposals for fiscal year 1981, as outlined in the fiscal year 1981 U.S. Budget and later sent to Congress in legislative form along with numerous additional amendments to medicare and medicaid. The administration's bill, however, was never introduced and no action was taken.

II. NURSING HOME ISSUES

The Federal involvement in nursing homes is tremendous. Of the approximately 26,000 nursing homes in the Nation, almost 20,000 voluntarily participate in the medicare and/or medicaid programs (5,500 in medicare and 18,500 in medicaid).

Tensions produced by conflicting demands to improve the quality of life for nursing home residents and contain escalating medicaid costs were evident throughout the year.

A review of all Federal requirements for nursing homes participating in medicare or medicaid was begun by the Health Care Financing Administration (HCFA) in 1978 and resulted in the first proposed changes to rules which originated in 1974. Considerable interest in the proposed regulations was generated during the public comment period, but no final decisions were made. Growing concerns about escalating medicaid costs were reflected in the debate on proposed changes and contributed to a slowdown in further development.

HCFA also began a review of Federal requirements for State survey and certification of nursing homes and the enforcement of required standards of care.

In Congress, the Federal mandate that States reimburse nursing homes on the basis of the costs of providing care was again challenged. A change in the law was made, but the impact of that change on the nursing home industry and the residents is unclear.

A. Nursing Home Regulations Proposed

Thousands of comments were received by the Department of Health and Human Services (HHS) on the proposed regulations for nursing homes participating in medicare and medicaid. New nursing home fire and safety rules were also proposed. Final rules on protection of nursing home residents' personal funds were issued in July, but did not become effective because of changes ordered by the Office of Management and Budget (OMB). The new administration has announced that all three of these initiatives will be fully reviewed before any further action is taken.

1. PROPOSED CONDITIONS OF PARTICIPATION FOR NURSING HOMES

In order to receive reimbursement for patient care from either medicare or medicaid, nursing homes must meet a set of minimum Federal standards for medical and rehabilitative care, living environment, staffing, and physical safety. These standards are referred to as "conditions of participation."

Current conditions of participation have been in force since 1974. During the past few years various criticisms have been leveled against the current standards including inadequate emphasis on the rights of nursing home residents; being vague and difficult to enforce; encouraging more attention to the paperwork required to prove compliance than to the outcomes of patient care; requiring both too little professional nursing care and too much professionalism among nursing home staff; and being generally out of touch with newer trends in nursing home care and more progressive standards as required by some States. Criti-

cisms of lax requirements for resident safety and care were often voiced by members of the Committee on Aging.[24]

In 1978, HCFA began a review of all nursing home conditions of participation, soliciting comments from consumers, public officials, and nursing home service providers. On July 14, 1980, new conditions of participation for all nursing homes participating in medicare and medicaid were proposed to expand resident rights and make them a full condition of participation.[25]

Resident Rights

As proposed, all nursing home residents would be guaranteed rights to personal privacy, to retain personal property in their rooms, and to purchase personal goods with their own funds from sources outside the nursing home. Residents would be given the right of free and private access to visitors, including nursing home ombudsmen and State nursing home inspection and survey personnel. As proposed, all nursing homes would be required to allow at least 12 hours of visiting time each day, and nursing home ombudsmen must be given access to any resident who wished to see them.

Nursing homes would also be required to allow residents to choose their own physician and permit residents access to their own medical records. Residents would have the right to form patient councils, to be protected against unnecessary drug or physical restraints, and to be informed in advance of any transfer to another nursing facility or to another room within the same facility.

Current nursing home regulations specify a number of basic resident rights but are stated as standards rather than a condition of participation. Only violations of a full condition of participation can serve as the basis for Federal sanctions against a nursing home. Therefore, the proposed change would make violations of resident rights a basis for sanction.

Other Proposed Changes

Increased training for nurses' aides, who provide most of the resident care in nursing homes, would be required. Nursing homes would also be required to assist residents in obtaining services which are not available through the nursing home, such as dental and podiatric services.

Conditions of participation for skilled nursing and intermediate care facilities would be unified, providing a single set of standards for nursing homes providing both levels of care.

The proposed changes would also require a comprehensive patient care management system in all nursing homes, bringing together

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[24] U.S. Congress. Senate. Special Committee on Aging. "Nursing Home Care in the United States: Failure in Public Policy." Introductory report and supporting papers 1 through 7, 1974–77. Also see the following more recent hearings chaired by members of the committee: U.S. Congress. Senate. Special Committee on Aging. "The Federal-State Effort in Long-Term Care for Older Americans: Nursing Homes and 'Alternatives.'" Hearings, Chicago, Ill., Aug. 30, 1978. Chaired by Senator Charles Percy.

U.S. Congress, Senate. Subcommittee on Federal Spending Practices. "Problems in the Procedures Now Used for the Medicare and Medicaid Certification of Skilled Nursing Facilities and Intermediate Care Facilities." Hearings, Washington, D.C., July and November 1978. Chaired by Senator John Heinz.

[25] "Conditions of Participation for Skilled Nursing and Intermediate Care Facilities." Proposed rule. Health Care Financing Administration. Federal Register, vol. 45, No. 136, Monday, July 14, 1980, p. 47368.

physician, nurse, rehabilitation, and social services specialists to develop a detailed individual plan of care for each resident. The resident and/or family would also have the right to participate, if they wished. A comprehensive assessment of each resident's physical, medical, and psychosocial condition would be required at the time of admission, and would be periodically updated as part of this process.

Reaction to Proposals

The reaction to the proposed rules was mixed. Advocates for nursing home residents, including a number of the largest organizations representing the elderly, supported the resident rights proposals but were disappointed that requirements for expanded nursing care were not included. Nursing home resident advocates were also very supportive of provisions to require that ombudsmen be given access to any resident wishing to see them. Provisions of the 1978 amendments to the Older Americans Act [26] which required every State to institute a long-term care ombudsman program also directed each State to establish procedures for ombudsman access to facilities and resident records. This provision of the proposed regulations was meant to help establish that access.

Support was voiced, particularly for the proposed resident rights, by the National Retired Teachers Association/American Association of Retired People, the National Council of Senior Citizens, the National Council on the Aging, the Citizen's Coalition for Nursing Home Reform, and the American Association of Homes for the Aging. Others, including many providers, criticized the proposed rules as being too costly and difficult to implement or enforce.

As originally proposed, the rules were to be open for public comment for 60 days, but the comment period was extended for another 30 days as a result of considerable public interest. Over 3,500 separate comments were received by HHS.

The Department had estimated that the total cost of implementing the rules, as originally proposed, would be about $80 million a year, largely from changes required by the new patient care management system.[27] A separate study commissioned by the American Health Care Association and the National Council of Health Centers, however, estimated that the total costs of implementation would be $535 million a year, including $185 million alone to provide visitors access to residents.[28]

During the Senate Appropriations Committee's consideration of a continuing appropriations resolution for fiscal year 1981,[29] Senator Henry Bellmon expressed concern over the cost estimates and proposed an amendment to prohibit HHS from finalizing any part of the proposed regulations during fiscal year 1981. This amendment was modified by Senator Lawton Chiles to make issuance of any of the proposed rules in final form contingent upon receipt of revised cost

[26] Public Law 95–478. Final regulations governing the ombudsman program were issued on Mar. 31, 1980. Federal Register, vol. 45, No. 63, p. 21151.

[27] U.S. Department of Health and Human Services, Health Care Financing Administration, Health Standards and Quality Bureau, "Regulatory Analysis, Proposed Conditions of Participation for Skilled Nursing and Intermediate Care Facilities." Washington, June 30, 1980.

[28] Applied Management Sciences, "Examination of the Economic Impact of the Proposed Medicare and Medicaid Conditions of Participation for Skilled and Intermediate Care Facilities, Prepared for American Health Care Association and National Council of Health Centers." Silver Spring Md., Aug. 29, 1980.

[29] H.J. Res. 644. Public Law 96–536.

estimates and an evaluation of the proposed regulations being prepared by the General Accounting Office (GAO).

At the end of the year, HHS prepared to issue final rules on residents' rights alone, at an estimated cost of $20 million a year.[30] No final action was taken, since the GAO report was not submitted to Congress until February. It will be up to the discretion of the new administration to decide whether or not to continue their development.

2. PROTECTIONS FOR PERSONAL FUNDS

HHS proposed regulations in September 1978, to implement provisions of 1977 and 1978 amendments to medicare and medicaid which require that all nursing homes establish accounting systems for handling a resident's personal funds.[31] The final rules, to be effective October 1, 1980, were published in July 1980.[32] The rules required all nursing homes to provide residents with an explanation of their rights regarding personal funds and a listing of services—not provided by the nursing home as part of its basic rate—which could be charged to their personal funds. Nursing homes were also required to set up an accounting system for personal funds, if requested by a resident; to keep resident personal funds separate from facility funds; and to deposit any personal funds in excess of $150 in an interest-bearing account. Nursing homes would keep a written record of all financial transactions made from personal funds and provide residents with quarterly statements of account.

Shortly before the effective date, however, the Office of Management and Budget (OMB), which must review all Federal requirements for recordkeeping, ordered a revision. A full review and revision must be completed before any new final rules are issued. Since the law requires accounting systems for personal funds, however, some additional action must be taken unless the law is changed.

3. FIRE SAFETY RULES

New rules were also proposed by HHS in July to require all newly constructed nursing homes to have automatic sprinkler systems as a protection against fire.[33] These will also be reviewed by the new administration before any final rules are published.

4. ENFORCING THE RULES: HCFA PROPOSALS

States are responsible for enforcing nursing home conditions of participation. A designated State survey agency determines whether or not a nursing home meets conditions of participation and certifies eligibility for reimbursement from medicare and medicaid. A separate State agency, usually the medicaid agency, is also required to perform

[30] Final regulations on residents rights were signed by then-Secretary Patricia Roberts Harris on Jan. 19, 1981, and withdrawn by the new administration on January 21. Federal Register, "Notice of Withdrawal of Secretarial Approval," vol. 46, No. 15, Friday, Jan. 23, 1981, p. 7408.

[31] Public Law 95–142 and Public Law 95–292.

[32] "Medicare and Medicaid Programs. Protection of Patients' Funds." Final regulation. Federal Register, vol. 45, No. 144, Thursday, July 24, 1980, p. 49440.

[33] "Medicare and Medicaid Programs. Automatic Extinguishment Systems for New Long-Term Care Facilities." Proposed regulations. Federal Register, vol. 45, No. 146, Monday, July 28, 1980, p. 50268.

reviews of resident care to determine the appropriateness of the care and whether the resident's condition meets medicare or medicaid eligibility guidelines. These reviews are either made by medicaid "inspection of care" teams or, in some areas of the country, by medicare professional standards review organizations (PSRO's).[34] Further, each nursing home is required to have an internal utilization review committee.

Many States have been severely criticized for lax enforcement of nursing home regulations, particularly in the survey and certification process. The Federal Government, which by law has a responsibility to insure that State enforcement activity is adequate, has also been criticized for not exercising its oversight authority with enough vigilance.

Elements of the proposed conditions of participation cited above were directed toward clearing up some of the ambiguities thought to contribute to enforcement problems. Additionally, HCFA announced its intent to conduct a review of all Federal requirements for certification, medical care evaluation, and utilization review. Meetings were held in all 10 Federal regions from March through June, and comments on a number of specific issues related to nursing homes were requested, including the following:

—How conflicting determinations of nursing home compliance with the conditions of participation made by State survey teams and State inspection-of-care teams (or PSRO reviewers) could be resolved. Proposals included requirements for exchange of reports between teams and setting more specific guidelines for inspection-of-care reviews to make them more consistent with survey team guidelines.

—Whether or not all States should be required to integrate the functions and administration of survey and inspection-of-care teams. Both surveys could be performed under the jurisdiction of the same State agency and/or the comprehensive evaluation now done by inspection-of-care teams could be reduced to a screening review.

—Whether or not States should be given more flexibility for conducting utilization review in intermediate care facilities, including elimination of utilization review committees in nursing homes.

—Whether or not a nursing home resident and/or family should be able to participate in the survey and certification process, helping to make determinations regarding a nursing home's certification for continued Federal funding. (The proposed conditions of participation discussed above would give a resident the right to meet with survey personnel.) A nursing home resident's right to have a say in decertification of a medicaid facility has been the subject of court debate. Since decertification means a transfer of residents to another facility, with possibilities of lifethreatening "transfer trauma," attorneys argue on behalf of residents for their participation. A recent U.S. Supreme Court decision, however, held that the residents of a nursing home are not cor-

[34] Only about one-fourth of approximately 200 PSRO's are currently credentialled to perform long-term care reviews.

stitutionally entitled to a hearing prior to decertification of the facility by the State or Federal Government.[35]

—Whether Federal regulations should allow States to survey nursing homes anywhere from every 3 months to every 2 years, based on past performance. (Currently, surveys are required every 12 months.) HCFA suggested that this would reduce administrative costs and paperwork as well as allow more concentration on those nursing homes which are frequently in violation of regulations. HCFA also suggested, however, that direct Federal surveys would be increased.

—Whether or not State surveyors should be required to meet minimum standards of skill and knowledge.

Many of HCFA's proposals were supported by the nursing home industry, so it is probable that this effort to revise Federal requirements for State enforcement activities will be continued by the new administration. No specific regulation changes, however, had been proposed by the end of 1980.

5. ENFORCING THE RULES: CONGRESSIONAL ACTIONS

Intermediate Sanctions

An amendment to authorize intermediate sanctions for nursing home noncompliance was signed into law in the 96th Congress.[36] The Secretary of HHS and State medicaid agencies are authorized to deny reimbursement for services provided to any new medicare or medicaid beneficiaries admitted to a nursing home after the home has been determined out of compliance with conditions of participation. Payments would be resumed once corrections were made. This "intermediate" sanction could be used only in cases in which the violations do not endanger the health and safety of residents. (If residents were in danger, the nursing home would be decertified immediately.)

Prior to the change in the law, the only sanction available was decertification of a nursing home, even if the violations did not endanger health and safety. Intermediate sanctions are supported by nursing home resident advocates and are seen as a way to provide a nursing home with incentives to improve conditions without having to subject residents to transfers to another facility.

Medicaid "Look Behind" Authority for HHS Secretary

The new law also authorizes the Secretary of HHS to question ("look behind") the results of a State nursing home survey and, if appropriate, terminate a nursing home's participation in medicaid.[37] Prior to this change, the Secretary had such authority only for medicare participation.

Congress also considered some changes in the compliance process which were not finally approved, including: (1) Repealing existing authority for medicare reimbursement to State survey and certification agencies for consultative services furnished to medicare skilled

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[35] U.S. Supreme Court, June 1980. *O'Bannon* v. *Town Court* (100 S.C., p. 2467).
[36] Public Law 96–499, effective Dec. 5, 1980.
[37] Ibid.

nursing facilities to help them remain in compliance with conditions of participation; and (2) continuing, until 1983, authorization for 100 percent Federal payment under medicaid for the costs of State nursing home inspectors.

The failure to extend the authorization for 100 percent Federal funding of nursing home inspectors means that as of October 1, 1980, the matching rate became 75 percent.

B. Further Challenges to Medicaid Cost-Related Reimbursement

The level of medicaid reimbursement to nursing homes and the methods used to determine appropriate rates are set by States.

Until the 1972 amendments to the Social Security Act, only very general Federal criteria were set for these payments. Criticisms of widely varying rates among States, particularly concerns about arbitrarily low rates which encouraged poor care, led to a change in the law. In 1972, Senator Frank Moss, a member of the Committee on Aging, won approval of section 249(A) of Public Law 92–603, which required States to provide medicaid reimbursement to skilled nursing facilities and intermediate care facilities on a "reasonable cost-related basis." The law directs States to develop their own methods and standards for determining cost-related rates, but the Secretary of HHS must approve and verify these methods. The 1972 amendments made the change effective by July 1, 1976.

1. EARLY DELAYS IN IMPLEMENTATION

Implementation was resisted, however, and final regulations for cost-related reimbursement were not even issued until July 1, 1976. At the same time, the regulations gave States until January 1, 1978, to implement the new standards, even though the law had set 1976 as the deadline. When the GAO ruled that HHS could not delay implementation beyond the 1976 date mandated by law, the Senate approved an amendment offered by Senator Henry Bellmon, to change the implementation date to January 1, 1979, as part of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977. The amendment was lated dropped in conference. A second amendment offered by Senator Bellmon later in the year was defeated on the Senate floor. As a consequence of the delays and confusion regarding intent, some States did not come into compliance fully until 1980.

2. FINANCE COMMITTEE DISCUSSES REPEAL

Early in 1979, during the Senate Finance Committee's discussions of ways to cut medicaid and medicare costs, a repeal of the "section 249" legislation was proposed. Initial estimates of medicaid savings from State reductions in nursing home rates and from lessened administrative reporting requirements, if the law was repealed, were between $50 and $75 million per year.[38]

[38] U.S. Congress. Senate. Committee on Finance. "Proposals for Medicare-Medicaid Reform and Overall Hospital Revenues Limitation," April 1979, committee print No. 96–10. (A later analysis by the Congressional Budget Office could predict no cost savings.)

Immediate concern was voiced by national aging organizations and others [39] that a repeal would mean substantially lowered quality of nursing home care and a move away from long-sought reimbursement mechanisms which could link payment rates to the quality of care received by nursing home residents. They were particularly fearful of the removal of any Federal oversight authority over how rates were determined. Others expressed concern that a repeal of reporting requirements would mean that a provider would be able to demand inflated rates from State medicaid agencies, leaving the States without the tools needed to verify the reasonableness of provider costs.

A compromise amendment was fashioned within committee deliberations, giving States more discretion to develop their own rate setting methodology but requiring that rates were sufficient to meet the necessary costs of facilities "which were efficiently and economically operated and which would assure the reasonable availability of long-term care services." [40]

Before any amendments were reported by the Finance Committee, GAO issued a report analyzing the proposed revised language. GAO found the proposed change would "effectively remove HHS from the ratesetting process" and recommended that the Federal Government maintain some control over nursing home payment rates since at least half of medicaid funds spent on nursing homes are Federal funds. GAO also reported that detailed cost reports required under the current law "had been important in detecting and prosecuting nursing home medicaid fraud, and necessary for assuring accurate reimbursement." GAO recommended that a State still should be required to file cost reports with the Federal Government. Without cost reports, according to GAO, the assurances of rates adequate to meet costs incurred by "economically and efficiently operated" facilities could not be verified. Overall, GAO said that it expected the final effect of the proposed change would be to increase nursing home reimbursements.[41]

Further informal negotiations in the Senate resulted in additional modifications, and the amendment reported by the Senate Finance Committee in December 1979, added language to directing States to give some assurances of compliance to the Federal Government.[42]

3. SENATE PASSES MODIFIED AMENDMENT

The amendment did not reach the Senate floor until June 1980, as part of the Omnibus Reconciliation Act of 1980.[43] Still concerned about significantly reduced Federal oversight of the medicaid nursing home payment process, Senator David Pryor, a member of the Committee on Aging, engaged in a colloquy on the Senate floor with Senator David Boren, the original author of the amendment to delete the cost-related reimbursement requirement from the law. Senator Pryor said:

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[39] Among them the American Association of Homes for the Aging, the National Citizens Coalition for Nursing Home Reform, the National Council of Senior Citizens, the National Senior Citizens Law Center, and the American Association of Retired Persons.

[40] Senate Finance Committee press release.

[41] U.S. General Accounting Office. "Potential Effects of a Proposed Amendment to Medicaid's Nursing Home Reimbursement Requirements;" report to the Congress by the Comptroller General of the United States. Washington, 1979. HRD–80–1, Oct. 15, 1979.

[42] Section 227 of H.R. 934. U.S. Congress. Senate. Committee on Finance. "Medicare-Medicaid Administrative and Reimbursement Reform Act of 1979; Report To Accompany H.R. 934." Washington, Rept. No. 96–471.

[43] The amendment was section 565 of H.R. 7765.

> The abuses in nursing homes documented by the Senate Committee on Aging and by recent media exposés underscore the need for a vigilant effort by the Federal Government to clean up the nursing home mess. While, as a former Governor, I strongly support the rights of States to develop flexible programs to meet the needs of their citizens, I believe these documented abuses in nursing homes can only be overcome by the force of Federal actions.[44]

Senator Pryor recounted the difficulties encountered by many States during the 6-year period required to comply with the original 1972 amendments, and cited the "basic accountability" and improvements in nursing home quality of care which had been provided through compliance with the existing law. He also expressed his concern over what he anticipated would be lengthy court battles:

> Even if my fears of a loss of Federal oversight are not realized, it is very difficult to predict how many States may become involved in legal challenges to their existing reimbursement systems in response to a change in the law.[45]

Consumer organizations also continued to oppose the amendment, and when it was considered by House and Senate conferees at the end of the year, it was again modified, as described in the conference report:

> . . . to clarify that, while the States have discretion to develop the methods and standards on which the rates of reimbursement are based, the Secretary retains final authority to review the rates and to disapprove those rates if they do not meet the requirements of the statute. The conferees intend that the Secretary shall exercise this review in a timely fashion . . . The conferees would further note their intent that a State not develop rates under this section solely on the basis of budgetary appropriations. . . ." [46]

The new language became effective on October 1, 1980. It is still unclear, however, what the changes ultimately will mean to the nursing home industry or nursing home residents. The final estimate of medicaid cost savings was $2 million.[47]

III. CURRENT FEDERAL FUNDING AND PROJECTIONS OF NEED

There is a growing consensus concerning certain basic services and supports which may be needed by many elderly and disabled to permit as full and independent functioning within society as possible. There is not, however, as certain a recognition of how much of these needs are—or are not—now being met, or of who should provide for them. Nor are there accurate measurements of the full costs, including both public and private contributions, to personal care supports for the elderly and disabled.

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[44] Pryor, David. Remarks in the Senate. Congressional Record, June 30, 1980, pp. S8926–27.
[45] Ibid.
[46] U.S. Congress. House of Representatives. "Conference Report To Accompany H.R. 7765. Omnibus Reconciliation Act of 1980." Washington, Rept. 96–1479.
[47] Ibid.

Direct Federal expenditures for certain basic services can, however, be used as a measurement of the current Federal role. Analysis of data from a number of surveys and studies also provides some new estimates of the size of the potential long-term care population.

A. Federal Spending on Long-Term Care Services

Direct Federal expenditures (excluding State contributions) for basic long-term care services in nine specific programs now "targeted" at a long-term care population were about $6 billion in fiscal year 1980. Almost 71 percent of this amount ($4.265 billion) is for skilled and intermediate care nursing homes. Not included are support in personal care and boarding homes provided through the supplemental security income (SSI) program, or programs of the Veterans' Administration which support institutional and community care.

Federal payments for services through the *medicare home health* program were $735 million in fiscal year 1980. The growing demand for these services and recent changes in the law will increase expenditures, and estimates are that medicare home health expenditures will grow to $912 million in fiscal year 1981 and $1.15 billion in fiscal year 1982.[48]

Federal payments for long-term care services through *medicare skilled nursing home* benefits were $365 million in fiscal year 1980. Without change in current policies toward medicare payments for skilled nursing home services, medicare expenditures are expected to rise to $387 million in fiscal year 1981 and $431 million in fiscal year 1982.[49]

Title XIX of the Social Security Act authorizes Federal matching payments to States for a range of health services to low-income individuals of all ages. Although the average Federal share is 57 percent, many States have a much higher Federal matching rate since the rate is based on the size of a State's low-income population. Federal payments through the *medicaid* program for care in *skilled and intermediate care nursing facilities* during fiscal year 1980 were $3.9 billion. Estimated Federal medicaid payments for these services are expected to increase to $4.6 billion in fiscal year 1981 and to $5.2 billion in fiscal year 1982.[50] This program represents the single largest component of Federal funding for all long-term care services for the elderly and disabled.

The medicaid program also provides significant funding for home health, adult day care, and personal care services for the long-term care population. Data are no longer collected separately from State medicaid plans on home health and personal care expenditures, but in fiscal year 1978 home health payments were estimated to be $211.3 million.[51]

Title XX of the Social Security Act authorizes Federal matching payments to States (at 75 percent) for the costs of providing a wide range of social services to low-income individuals of all ages. Total Federal expenditures in this program are capped, by law, at $2.7 bil-

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[48] Source: Budget of the U.S. Government, fiscal year 1982, op. cit.
[49] Ibid.
[50] Source: Health Care Financing Administration, Department of Health and Human Services. Figures do not include medicaid payments to intermediate care facilities for the mentally retarded or other domiciliary care homes.
[51] Source: HCFA.

FIGURE 1.—DIRECT FEDERAL PAYMENTS FOR SELECTED LONG-TERM CARE SERVICES[1]

[Dollar amounts in millions; fiscal years]

Source of funding	Institutional care			Community-based and in-home services		
	1980	1981	1982	1980	1981	1982
Medicare (title XVIII of SSA):						
Home health services				$735	$912	$1,150
Skilled nursing facility	$365	$387	$431			
Medicaid (title XIX of SSA):						
Home health services				212		
Skilled and intermediate care nursing facility	3,900	4,600	5,200			
Social services grants (title XX of SSA):						
Homemaker/chore services				540	580	600
Adult day care and home-delivered and congregate meals				67		
Older Americans Act:						
Congregate and home-delivered meals (title III–C)				390	435	478
In-home services (title III–B)				32	32	32
HUD housing services: Congregate services (title IV, 1978 Housing Act)				10		

[1] All sources and explanations contained in accompanying text.

lion for fiscal year 1980, rising to $3.1 billion by fiscal year 1983. One of the fastest growing categories of services provided by States through the title XX program is homemaker and chore service. Services are provided to individuals of all ages, but a majority of recipients are elderly. Federal *title XX* payments to States for *homemaker/chore services* were $540 million in fiscal year 1980. Federal expenditures for this type of service, under current spending ceilings and State title XX plan allocations, are expected to increase to $580 million during fiscal year 1981 and $600 million during fiscal year 1982.[52]

The title XX program also makes significant payments for *adult day care services and home-delivered and congregate meals.* During fiscal year 1980, estimated Federal title XX payments for these services were about $67 million.[53]

A fourth significant, although smaller, source of Federal funding for community and in-home services is title III of the *Older Americans Act.* During fiscal year 1980, direct Federal expenditures for *congregate and home-delivered meals* were about $390 million (including Department of Agriculture commodity support). Future levels are subject to congressional appropriations action, but expenditures are expected to reach about $435 million in fiscal year 1981, and $478 million in fiscal year 1982.[54]

In-home services funded under title III of the *Older Americans Act* during fiscal year 1980 were about $32.1 million. Expenditures for fiscal years 1981 and 1982 will also be determined by congressional appropriations, but the administration's budget request assumed no increases.[55]

The Department of Housing and Urban Development administers a comparatively small program of funding for congregate meals and other essential "in-home" support services for some residents of public housing for the elderly and disabled. This program of congregate services, authorized by Public Law 95–557, was funded by Congress

[52] Source: U.S. Budget, fiscal year 1982 op. cit.
[53] Source: State title XX plans, Office of Human Development Services, Department of Health and Human Services. No estimates are available for future years.
[54] Source: U.S. Budget, fiscal year 1982 op. cit.
[55] Ibid.

at a level of $10 million in fiscal year 1980. A continuing appropriations resolution has provided for an additional $10 million in fiscal year 1981, but the administration has requested a rescission of this amount and no funds have been requested for fiscal year 1982.

B. The Long-Term Care Population

In its report to the new administration,[56] the Under Secretary's Task Force on Long-Term Care defined what it called a "target long-term care population" of approximately 6 million individuals who currently are either:

(1) Living in the community, but who need help with personal care and activities of daily living and/or help with maintaining a household (3.9 million—identified as the population in level III in the table below, as well as about 300,000 additional individuals in level IV).

(2) Living in institutions (1.8 million); or

(3) Disabled and living in board and care homes (0.6 million).

About half of the target group living in the community (2 million) have resources and living arrangements which can make it difficult for them to continue living outside a nursing home. Over 40 percent have family incomes below $6,000 a year, and about 20 percent live alone.

Based on projections of population growth, particularly among older Americans, the task force estimated that the target long-term care population (of 6 million) could increase from 25 to 50 percent by 1990—to between 7.5 and 9 million people.

If current trends of care are constant, the task force estimated that one-third of those included in this increase (from 2.5 to 3 million) will become institutionalized, bringing the institutional population to approximately 4.8 million.

Another one-third (from 2.5 to 3 million) will be added to the 3.6 million individuals with functional disabilities currently living in the community—bringing the population of those who are living in the community but who cannot maintain a household without help to approximately 6.6 million.

The table below illustrates these estimates, based on a classification of types of functional disability and assumptions of service and support needs. Further improvements in measurement of disability and functional impairment related to support needs will certainly mean that changes in classification and definitions of a "long-term care population" will be made in the future. The Federal Council on Aging, for example, is now preparing such estimates, and the Department of Health and Human Services is planning surveys to gather new long-term care data. These estimates, however, represent a refinement of earlier estimates prepared by the Congressional Budget Office which have been widely used.[57]

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[56] "Report of the Under Secretary's Task Force on Long-Term Care." Department of Health and Human Services, staff draft, Jan. 9, 1981.

[57] "Long-Term Care for the Elderly and Disabled." Budget issue paper, Congressional Budget Office, Congress of the United States, Washington, D.C., February 1977. The CBO estimated then that 1.6 million people of all ages were institutionalized in 1976, and that this institutionalized population would increase to 3 million by 1985. CBO also estimated that the range of noninstitutionalized functionally disabled individuals living in the community was between 3.9 and 8.3 million in 1975, and expected to increase to between 4.5 and 9.6 million in 1985.

There is very little information regarding the extent to which these needs are being met already or in what ways. In general, studies indicate a large proportion (about 80 percent) of the personal care support services now being provided to individuals living in the community come from a network of "informal supports," such as family and friends.

ESTIMATES OF POPULATION NOW LIVING IN THE COMMUNITY WITH SOME FUNCTIONAL LIMITATIONS [1]
(NONINSTITUTIONALIZED)

Level of functional disability	Service/support needs	Number of people	Percent of group (within level) with incomes under $6,000 per year	Percent of group (within level) who are living alone
I. Some chronic conditions; no severe disability.	Health and rehabilitation services.	(2)	(2)	(2).
II. Cannot work; cannot engage in major activities.	Above, plus income support.	7.7 million (3.8 million aged 65 or older).	40 percent, or 3.1 million.	15 percent, or 1.2 million.
III. Cannot maintain a household without help.	All above, plus mobility assistance; household and community services.	3.6 million (2.1 million aged 65 or older).	41 percent, or 1.5 million.	20 percent, or 0.7 million.
IV. Full disability	All above, plus personal care and assistance with activities of daily living (bathing, dressing, eating, etc.).	1.6 million (1 million aged 65 or older).	36 percent, or 0.6 million.	11 percent, or 0.2 million.

[1] All information taken from analyses in Report of Under Secretary's Task Force on Long Term Care, Department of Health and Human Services, staff draft, Jan. 9, 1981.
[2] Not applicable.

IV. A MOMENTUM FOR CHANGE

A Task Force on Long-Term Care in the Department of Health and Human Services and preparations for the 1981 White House Conference on Aging all contributed to a sense of momentum for change in Federal long-term care policy during the year.

The shortcomings of the current system are no longer the subject of debate, and consensus is broadening on some long-range policy goals.

A. Preparations for 1981 White House Conference on Aging

Organization for a focus on long-term care issues in the 1981 White House Conference on Aging [58] began early in 1980, with the formation of a Long-Term Care Technical Advisory Committee. Members of the committee, with broad representation from a wide range of disciplines, met throughout the year to prepare a working outline of long-term care policy options and recommendations for use by conferees. A Mini-White House Conference on Aging was held in December, and a symposium on long-term care policy options was convened in June.

1. SYMPOSIUM ON LONG-TERM CARE POLICY OPTIONS

Preliminary plans for long-term care discussion at the 1981 White House Conference on Aging were put in motion early in 1980 through preparations for a national symposium on long-term care policy op-

[58] Authorized by the 1978 amendments to the Older Americans Act, Public Law 95–478.

tions, sponsored by the Administration on Aging. Papers analyzing the "state of the art" in six important issue areas were commissioned by a national steering committee in anticipation of the symposium, which was convened in Williamsburg, Va., in June 1980.[59]

The symposium report, which is expected to be used during a series of regional White House Conference on Aging meetings early in 1981, expressed what may be a keynote message for conferees:

> Momentum for change is building, not only because of the growing numbers of people seemingly at risk for assistance, but also because of a realization by numerous visible constituencies (professionals, politicians, taxpayers, and persons in need of care) that the way in which long-term care services are financed, organized, and made available is fraught with problems. Much of the frustration has focused on our inadequacies in caring for those who suffer from chronic disabilities. Many of these persons are old but the problem cannot be limited or defined by age. The problems of long-term care have become a symbol of America's traditional rejection of dependency and our seeming callousness to the problems that accompany chronic illness and disability.[60]

The symposium identified the following major policy issues needing resolution:

(1) A lack of consensus about the nature and extent of public responsibility for meeting long-term care needs results in an inability to articulate a coherent set of goals and directions for future policy development. Since there is such a momentum for change, however, the development of Federal policy should proceed immediately on the basis of general consensus on goals and objectives. New information is still needed to develop a long-term perspective, including estimated costs, but the call for new knowledge should not be used to defer immediate steps toward change.

(2) Assumption of public responsibility for long-term care and subsequent programs should protect existing familial and informal care arrangements. Beyond financial support, however, few methods have been suggested to insure that care by families is not replaced, and this should be a high priority issue for further research and investigation.

(3) A definition of need must be developed, along with eligibility criteria, before any rational allocating of scarce resources can be derived. These criteria have not yet been developed, therefore, policy may have to follow three related courses: An initial target population for long-term care services linked to a demonstrated need for care

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[59] "The Extent and Nature of Public Responsibility for Long-Term Care"; "Health and Social Factors Relevant to Long-Term Care Policy"; "Allocating Long-Term Care Services: The Policy Puzzle of Who Should Be Served"; "Delivery of Services to Persons With Long-Term Care Needs"; "Finding the Money and Paying for Long-Term Care Services"; and "Cost Estimation and Long-Term Care Policy: Problems in Forecasting the Undefined."

[60] "Federal Policy Directions in Long-Term Care," draft report prepared for symposium on long-term care policy options, June 11–13, 1980, Williamsburg, Va. Center for Study of Welfare Policy, the University of Chicago. Revised Sept. 3, 1980.

based on the presence of functional limitation; no arbitrary age cutoff for publicly supported long-term care eligibility; and the immediate goal may have to be to direct public support and subsidy first to low-income individuals who need care.

(4) The current long-term care system places an overemphasis on institutional and acute care. Financial incentives for States and localities should be altered to make noninstitutional care more attractive. Federal policy must rely less on medicaid as part of an attempt to demedicalize long-term care.

(5) A major shortcoming of long-term care is the pervasive absence of personal care services and other social supports which can assist the individual to live in the community. Federal policy should therefore focus on expanding the availability of social supports to obtain a more appropriate and cost-effective balance between personal care services and medical care as well as housing and income maintenance. Further, the social support system should retain its own integrity, and should not be conceived as a subsidiary of medical care.

(6) There is a wide variation in current State and local financing and availability of long-term care services. Federal policy should seek to reduce these imbalances through mandates requiring service development at uniform minimum levels in all States. No single model of service delivery, however, should be insisted upon by the Federal Government, and any developing policy should look to the diverse approaches and experiments now underway in many States and local areas.

(7) In order to achieve coordination and access to the multiple human services needed by many long-term care clients, long-term care must be conceptualized as requiring at least four major types of support (income adequacy, health care, social supports, and adequate housing). These services must be capable of tailoring to individual needs and conditions. Policy and program alteration should proceed on multiple fronts, through coordinated change in current systems of income support, health care, personal and social services, housing, and institutional care.

(8) Scant attention is being given to housing as a critical component of long-term care, and Federal policy in long-term care should have an explicit focus on increasing the range and number of supported housing opportunities for the long-term care target population.

(9) Efforts to coordinate services, including case management, will be necessary under any new approach, but they are not a strategy for change. Federal policy should not place primary emphasis on coordination of existing services.

(10) Much more care and consideration must be given to all the manpower implications of proposed long-term care policies, including issues of overprofessionalization and making caretaking roles more attractive.

(11) Regardless of the Federal policy pursued, ongoing efforts must be devoted to resource development, including initiation and development of new services in many communities, and staff training and development. This need is particularly acute in rural areas.

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2. MINI-WHITE HOUSE CONFERENCE ON LONG-TERM CARE

In December 1980, a Mini-White House Conference on Long-Term Care was sponsored by a broad coalition of long-term care service providers, including national organizations representing home health agencies, nursing homes, hospitals, and State and area agencies on aging.[61] The final report of the conference [62] focused on issues of immediate concern:

> Long-term care has been identified repeatedly as one of the major areas of concern for the 1981 White House Conference on Aging. While the problems which exist in the current system of long-term care have been enumerated and analyzed from many perspectives over the past several years, a consensus has yet to be reached among those in the field of long-term care on a resolution of the problems at the Federal, State, and particularly, the community level. Needs assessment, cost factors, and utilization are but a few long-term care issues which provoke far-reaching public debate. Recognizing these as major problems, the conveners of the miniconference on long-term care saw a need for policy direction and a need to stimulate action to strengthen community-based long-term care specifically for individuals. An attempt was made to move away from a discussion of whether we should allocate substantial resources to long-term care, to a discussion of how we can develop a viable program to most effectively provide individuals with the care they need.
>
> To best meet the changes that long-term care will inevitably undergo in the next several years, and to facilitate some of those changes, the long-term care community has recognized that it must begin to conduct a serious dialog and to work together on the basis of full cooperation.
>
> Several significant assumptions provided the parameters for these discussions: The budgetary situation facing long-term care will become even more severe and resources that have long been taken for granted will simply not be available; the role of the Federal Government in the provision of services will become less vital; the current system will continue to be inadequate to meet the needs of the increasing number of elderly individuals. These assumptions have several noteworthy implications for the future, about which there was a consensus among the participants at the conference: There is no one system which will be appropriate for every individual in need of services in each community; the emphasis on the community and on the informal support structures will increase sizably; and a partnership needs to

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[61] The conference was coordinated by the American Association of Homes for the Aging and the National Homecaring Council. Additional sponsors were the American College of Nursing Home Administrators, American Health Care Association, American Hospital Association, Council of Home Health Agency Community Health Services of the National League of Nursing, Home Health Services and Staffing Association, National Association of Area Agencies on Aging, National Association for Home Health Agencies, National Association of State Units on Aging, and National Council of Health Centers.

[62] "The Mini-White House Conference on Long-Term Care." Draft final report, Jan. 16, 1981.

be created between the Government and the private sector on the financing and delivery of services.[63]

In general, conferees recommended that:

—Focused and comprehensive planning for a continuum of long-term care services, institutional and noninstitutional, should occur at Federal, State, and local levels. Different levels of emphasis and responsibility should be prescribed for each level, but maximum flexibility should be preserved at the State and local levels.

—At all levels, provision must be made for the fullest involvement of the consumer of long-term care services. Recipients of any system must be assured of options and freedom of choice. At all levels, provision must also be made to include the broadest range of existing planning systems (health, mental health, e.g.) and service providers, including voluntary and private providers.

—Responsibilities of a long-term care system should include, at each level, coordination of current system efforts, development and enforcement of quality of care standards, and development of service priorities, to assure meeting the real needs of those in need of long-term care services with scarce resources.

Conferees also urged support for increased and improved utilization of long-term care research and evaluation efforts to support development of a long-term care system.

B. The Under Secretary's Long-Term Care Task Force

Late in 1979, the Secretary of the Department of Health and Human Services (HHS) announced the formation of a departmentwide task force on long-term care policy to develop policy goals, coordinate research and demonstration activities, and review and initiate proposals for long-term care reform.[64] The task force was chaired by the Under Secretary of the Department, with membership at the assistant or deputy assistant secretary level from Department offices responsible for planning, budget, and administration of the medicare, medicaid, social security, and public health programs.

In a report[65] to the new administration's incoming Secretary of HHS, the task force reiterated major shortcomings of the current long-term care system:

—The system is fragmented with no mechanisms to effectively identify and coordinate services.

—Community-based services are appropriate alternatives to institutional care for some, but the supply of these services is far too limited.

—The major source of long-term care assistance is private and should continue, and ways to provide support to families who are providing care must be found.

—States are seeking flexibility among funding sources and are experiencing difficulties due to differences in Federal programs.

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[63] Ibid.

[64] In a letter to Senator Lawton Chiles, chairman, Senate Committee on Aging, Nov. 27, 1979. See also, "Developments in Aging: 1979," part 1, p. 85.

[65] Report of the Under Secretary's Task Force on Long-Term Care, op. cit.

—Criteria used to assess quality of long-term care services is lacking, and little progress has been made on applying criteria in non-institutional settings; and

—The best strategies for prevention and management of chronic disabling conditions have not been determined.

The task force concluded that "there is no single answer to this multifaceted problem" and recommended that the Department:

—Work to assure balance, or "neutrality," in its programs so they do not lead to unnecessary or inappropriate institutionalization. Institutional care, however, should remain available to those for whom it is the preferred alternative.

—Encourage and support the development of alternatives to nursing homes for all those for whom it is appropriate in terms of cost and quality.

—Give high priority to quality assurance mechanisms in both institutional and community settings.

Noting that "certain solutions require more budgetary resources than will be available over the next few fiscal years, and that (the Department's) information base is inadequate to adopt others at this time," the task force recommended that HHS move immediately to develop a comprehensive long-term care data base through coordinated departmentwide research and demonstration activities and conduct thorough reviews of basic approaches to quality assurance in institutional and community settings and current long-term care financing systems. The task force also recommended developing joint working plans between the Departments of Housing and Urban Development, Veterans Administration, and Agriculture, to find the best ways to expand the range of service-enriched living environments (such as congregate housing with services) with emphasis on innovative private sector and government interactions; identifying ways to make current HHS programs more supportive of spouses, families, or friends providing care to the elderly and disabled; and making a systematic and thorough examination of screening and assessment to identify the most appropriate locus of responsibility and point of intervention.

The task force challenged earlier estimates of the extent of inappropriate institutionalization, which were believed to be within a range of 15 to 40 percent of all individuals in acute care hospitals and nursing homes, as too high. They conceded, however, that "practical experience in a number of areas and demonstration projects indicate that where people can be linked to appropriate alternative services, a significant proportion can be maintained in the community."

Among other conclusions:

—Evaluations of newer forms of congregate housing which emphasize service packages and architectural design features which promote independence seem promising because of their effect on residents, their flexibility, and their costs. Very little is known however, about the cost-effectiveness of congregate housing in preventing institutionalization compared to home-based services.

—Current evidence is inadequate to conclude that there is a surplus or shortage of nursing home beds and other long-term care serv-

ices and settings; that is, whether needs exceed current utilization. Choices of living arrangements available to the elderly, however, have narrowed in the past 50 years. (The task force explains that its conclusion here is based on a lack of information about a number of factors which would affect decisions about the supply of services, such as how many individuals are now inappropriately placed, the effect of a lack of alternatives, consumer preferences, whether or not shifts would take place if alternatives were available, and whether or not public reimbursement is more in control than the actual supply of beds. The task force also notes that the supply situation differs by State.)

No recommendations were made to the new administration beyond continued research and attention to long-term care issues.

Chapter 5

ENERGY ASSISTANCE PROGRAMS

CHAPTER HIGHLIGHTS

The trend continued. During 1980, energy prices steadily climbed to record rates as the full impact of decontrol, additional OPEC price hikes and the war in the Middle East affected the world's oil supply. As the price of crude oil escalated, the burden on the consumer rose accordingly. A Department of Energy advisory committee projected that during 1980, the low-income household was spending, on the average, at least 35 percent of its income on energy. The advisory committee reported that low-income households will continue to pay four times more the percentage of their income on energy than the average American household, but will use less than 50 percent of the total energy consumed by that average household.[1]

The demand for assistance to combat rising energy prices was even greater in 1980. A major new program, the Home Energy Assistance Act, was enacted to respond to the growing need. However, administrative and financial problems curtailed the effectiveness of the program. Under new regulations, States struggled to draft plans which would serve their various parochial needs.

The unusually hot summer of 1980 documented the serious impact of severe heat on individuals, especially the elderly. The Federal Government attempted to respond to this critical situation which took the lives of approximately 2,000 persons. However, gaps in the Government's ability to act were evident. At a minimum, there was a recognition that assistance for "cooling" as well as heating is justified under the Government's program in cases of medical necessity.

Legislation to reauthorize the weatherization program for low-income households under the Community Services Administration died at the end of the 96th Congress. However, Congress approved a 1-year extension of a small-scale weatherization program for the low income under the Department of Energy. Prospects for expansion of a weatherization program by the 97th Congress are uncertain.

I. A YEAR OF ANALYSIS AND PLANNING

During 1980, the States concentrated on implementing an energy assistance program which was loosely authorized by language contained in the 1980 appropriations bill (Public Law 96–126). In fact, a good portion of the program was handled by the Federal Government,

[1] U.S. Department of Energy, Economic Regulatory Administration, Fuel Oil Marketing Advisory Committee, "Low-Income Energy Assistance Programs," Washington, D.C., July 1980.

which issued energy assistance payments to elderly and disabled supplementary security income (SSI) recipients.

While administering the 1980 program, the States also had the task of drafting a State plan for the much more comprehensive 1981 energy assistance program. The new program, the Home Energy Assistance Act of 1980, was enacted as title III of the Windfall Profits Tax Act (Public Law 96–223).

The Home Energy Assistance Act of 1980 contains a provision which requires priority attention to households with an elderly member. This amendment, sponsored by the entire Senate Committee on Aging, necessitated special planning by the States to provide outreach and benefits for the elderly.

The Senate Committee on Aging, in an effort to hear from the elderly and program administrators about recommendations for the 1981 program, continued the committee's series of hearings on "Energy Assistance and the Elderly."

At a hearing in Pennsauken, N.J., Senator Bill Bradley, who chaired the meeting, described the burden of energy prices on older persons. "By last winter," he said, "which was relatively mild, low-income older persons were using almost 48 percent of their limited incomes for energy costs. Almost 50 percent of their income therefore was going for heat and electricity. It was no longer difficult for many elderly to pay their utility bills, it was impossible." [2] This burden was put in more human terms by an elderly woman who testified before the committee in Maine:

> My grandsons finished off two rooms upstairs, but I keep them closed off to save heating costs. In the winter, I close off the bedroom too, and heat only the kitchen, sitting room, and bath. During the winter, I sleep on the couch. I always keep the thermostat set at 65 and wear insulated underwear, heavy sweaters, slacks, and wool socks. Even doing that, my heating bill jumped from $450, 2 years ago, to $923 last winter. Without the ECAP program (energy crisis assistance program) I would have frozen to death for sure. I hated to ask for help last winter; my husband and I had made it for 48 years on our own, but I couldn't cut back any more without my pipes freezing.[3]

In addition to the fear of freezing pipes, many elderly also fear illness brought on by extreme cold to which they are far more susceptible than other age groups. As Senator William Cohen, who chaired the Maine hearing, pointed out:

> Although willing to conserve, many older persons cannot reduce the temperatures in their homes below a certain point without potential danger to their health—even the risk of hypothermia. For these elderly poor, being too cold is not merely an inconvenience.

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[2] U.S. Senate Special Committee on Aging hearing on "Energy Assistance and the Elderly," May 23, 1980, Pennsauken, N.J.

[3] U.S. Senate Special Committee on Aging hearing on "Maine's Rural Elderly: Independence Without Isolation," June 9, 1980, Bangor, Maine.

Program administrators across the country made similar recommendations to the Committee on Aging which would help meet the needs of the elderly under the new program. One suggestion was to make funds available at earlier dates in order to allow States the necessary time to prepare for the program.

An administrator in New Jersey suggested utilization of the elderly as outreach workers and laborers for the low-income weatherization program.

As the director of Maine's energy program pointed out:

> Conservation and crisis assistance programs are not the total answer for Maine. We need to integrate public education, weatherization, housing rehabilitation, and fuel assistance. Presently, elderly people whose homes are dilapidated because they can no longer afford to maintain them are being forced into nursing homes. Houses are being vacated and left to rot at a time when there is a housing shortage. Something must be done to stop this trend of spending millions of dollars to keep people barely warm in inadequate housing.[4]

An area agency aging director from Florida suggested that States be required to maintain a list of high-risk elderly residents in order to provide assistance more expeditiously. He explained:

> Florida's service providers have, in the past 7 months, been focusing their attention on identifying those persons with physical or mental limitations that restrict individual ability to perform the normal activities of daily living and which impede individual capacity to live independently with the provision of services. These functionally impaired individuals are the people most likely to need extraordinary attention in any crisis situation and were the first persons contacted as the temperatures reached critical levels.[5]

The growing importance of the home energy assistance program benefits to the consumer was underlined for the Aging Committee by a fuel dealer from New Jersey, who explained that many fuel merchants, especially the small companies, could no longer let consumers bills ride. He explained:

> Our members (Fuel Merchants Association) have traditionally operated assistance programs of their own. Before the recently announced tightening of credit terms by the major oil companies, it was historical practice for home heating oil distributors to refrain from terminating service to any customer during the heating season because of a failure to pay any outstanding bills within a reasonable period. In practice, this resulted in extension of credit as long as 60 to 90 days for senior citizens and the economically disadvantaged, often extending into late spring and summer. . . . The recent dramatic increases in the price of home heating oil,

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[4] U.S. Senate Special Committee on Aging hearing on "Energy Equity and the Elderly," Oct. 24, 1980, Boston, Mass.

[5] U.S. Senate Special Committee on Aging hearing on "Energy Assistance and the Elderly (Impact of the 1980 Heat Wave)," July 25, 1980, Washington, D.C.

coupled with the tightening of credit terms by the major suppliers, foreclosed to members of our association the luxury of extending 60- to 90-day credit terms to great numbers of our customers. Slow payments across the board by virtually all end-consumers meant that it was no longer possible to carry on our historical practice of carrying fixed- or low-income customers for long periods, if we were to keep our businesses financially afloat. The new market conditions have forced our members to borrow so heavily to cover the financing of inventory that we could no longer depend on lending institutions to help finance our accounts receivable as well.[6]

In response to these remarks, Senator Bradley pointed out that the Home Energy Assistance Act requires the fuel suppliers to carry the resident for 60 days. This requirement was described by the fuel dealers as a major problem and a disincentive for dealers to supply households who receive assistance under the Home Energy Assistance Act.

In summary, the hearings substantially documented that the unprecedented energy crisis which grips the world is a major problem for program administrators, local officials, and fuel dealers, but a cruel, often unbearable burden, for the elderly.

The Home Energy Assistance Act of 1980 is intended by the Congress to help alleviate this burden.

II. THE HOME ENERGY ASSISTANCE ACT OF 1980

A. A New Authorization

The Home Energy Assistance Act of 1980 (Public Law 96–223) significantly expands upon the 1980 program. Major provisions in the program are described below:

—The new law requires that "priority be given to households with lowest incomes and to eligible households with at least one elderly or handicapped individual . . ." The former Secretary of Health and Human Services, Patricia Roberts Harris, described this "priority" as ease of application process, access to assistance, and timing of benefits or guarantees of assistance if program funds are inadequate.[7] The regulations governing the new law reflect the Secretary's definition but add that the "State plan must describe how priority will be given to eligible households with elderly or handicapped persons." [8]

—Eligibility, under the new law, is "an income equal to *or less* (emphasis added) than the lower living income standard." This level, which differs among regions of the country and between metropolitan and nonmetropolitan areas, will result in different eligibility levels among the States. In addition, eligibility levels will differ within the States as the continuing resolution which authorizes the program's funding for 1981 (Public Law 96–536)

[6] U.S. Senate Special Committee on Aging hearing on "Energy Assistance and the Elderly," May 23, 1980. Pennsauken, N.J.

[7] Letter to Senator Lawton Chiles, chairman, U.S. Senate Committee on Aging, from Patricia Roberts Harris, Secretary, Department of Health and Human Services, Sept. 15, 1980.

[8] Federal Register, vol. 45, No. 196, Oct. 7, 1980, p. 66695.

allows States to use either the lower living income standard or 125 percent of the poverty level in determining eligibility for single-person households. This allowance was added when it became evident that in some regions of the country, 100 percent of the lower living income standard would be a lower amount than the 125 percent of poverty level used under the 1980 program. Many States determined that some persons receiving assistance during 1980 would be ineligible in 1981 under the lower living income standard. This allowance is especially important for elderly persons as persons aged 60 and over make up the largest percentage of one-person households.

—States have the option of utilizing automatic eligibility for recipients of SSI, AFDC, food stamps, and certain veterans benefits. State agencies can make payments directly to the recipients or through vendors (energy suppliers) in contrast to last year when SSI recipients were paid directly by the Federal Government. States can still exercise the option of Federal payments to their SSI recipients, but many are now expected to make the payments through State channels in order to better target energy assistance. However, in most States this will mean each recipient must apply to receive the payment and cannot expect to receive a "bonus check" in the mail as they did last year.

—The need for adequate outreach efforts is underlined by the above described required application process. The Home Energy Assistance Act requires that each State plan includes "outreach activities designed to assure that all eligible households, particularly households with elderly or handicapped individuals, households with individuals who are unable to leave their residences, households with migrants, households of individuals with limited English proficiency, households with working poor individuals, households with children, and households in remote areas, are aware of the assistance under this title . . ." In addition to this requirement for every State, the Director of the Community Services Administration (CSA) is authorized to enter into agreements with national aging organizations for the purpose of providing special outreach efforts on behalf of elderly persons. For this effort, the Director is authorized to use up to $3 million for each fiscal year of the program.

—The amount of assistance for households may differ. The law allows States to determine each household's benefit level based on the household's income, household size, energy costs and the climatic condition of the region. However, the law requires that the highest level of assistance be provided to or on behalf of those households with the lowest income and highest energy costs.

—States may use up to 7½ percent of their allocation for administering their programs. States are not required to match the Federal dollars but must pay, from non-Federal sources, all administrative costs which exceed the allowable 7½ percent Federal share.

—States are allowed to provide assistance to a household to help meet the rising costs of "cooling," but only when households show that cooling is a medical necessity in accordance with standards established by the Secretary of Health and Human Services. In

addition, States are allowed to set aside up to 3 percent of their allocation for weather-related emergencies. These funds, unlike the assistance payments, can be used for cash payments as well as for goods and services necessary to respond to the emergency situation.

—The Home Energy Assistance Act specifically disregards any assistance payments or allowances under this program as income when determining benefit level and eligibility for other programs. Considerable misunderstanding about this provision arose chiefly due to the use of vendor payments when the recipient receives a reduction in utility bills, but no direct cash assistance, and resulted in different interpretations by various States and agencies. The food stamp program was most seriously affected by this provision. As of January 1, 1981, a recipient is eligible for a shelter deduction of $115 per month. Therefore, if one's shelter expenses are reduced by a vendor who has received an energy assistance payment on behalf of that resident, the resident could receive a smaller food stamp allotment.

To clarify congressional intent on this issue, the Senate-House conferees determining appropriations on the continuing resolution for fiscal year 1981, included language specifying that any assistance under the Home Energy Assistance Act shall not result in a reduction of benefits provided under the Food Stamp Act. In remarks on the House floor, Congressman Silvio Conte of Massachusetts further clarified the legislative intent, stating:

> It appears that beneficiaries under the home energy assistance program who receive their energy benefits in the form of direct vendor payments will have their food stamp benefits reduced accordingly. Meanwhile, beneficiaries receiving those same energy assistance payments in the form of cash will not have their food stamp benefits reduced by the amount of energy assistance they receive.
>
> Clearly, this double standard is not the intention of the authorizing legislation, nor the intention of the conferees. It is the stated intention of Public Law 96–223 authorizing the home energy assistance program that other benefits not be reduced as a result of these energy assistance benefits.[9]

B. Appropriations Debates

The authorization for the new Home Energy Assistance Act (Public Law 96–223) provided for a $3.1 billion level for fiscal year 1981. The President's original budget request (January 1980) called for a level of $2.4 billion for 1981. The President's revised budget (March 1980), influenced by an election year and pressures to "balance the budget," reduced the request to $2.2 billion, only $400 million above the 1980 level of $1.6 billion.

The "balance the budget" mood also persuaded members of congressional Budget and Appropriations Committees to reconsider funding levels for many programs, including energy assistance. The House

[9] Conte, Silvio. Remarks on conference report on H.J. Res. 637 (continuing resolution), Congressional Record, vol. 126, Dec. 13, 1980; p. H12425.

Budget Committee recommended only $1.8 billion for fiscal year 1981 and the House Appropriations Committee concurred with this level. In the Senate, the Budget Committee recommended a $2 billion level. During the markup of the continuing resolution for fiscal year 1981 (Public Law 96–536), members of the Senate and House Appropriations Committee, after extended debate, finally agreed upon a level of $1.85 billion.

Much of the debate on the energy assistance programs during the markup of the continuing resolution centered on the allocation formula for the program. The House of Representatives ignored the formula contained in the authorization legislation (Public Law 96–223) and instead weighted the formula in favor of the colder States. The sunbelt Members of the Senate insisted upon a more equitably weighted formula which would take into consideration the needs for cooling assistance. Members argued that record high temperatures of the summer which resulted in nearly 2,000 deaths, documented the need for cooling assistance. Conferees finally agreed upon a compromise which retained the House formula weighted in favor of the cold States, but added a hold-harmless provision which assured that no State would receive less than 75 percent of the allocation they would have received under the authorization formula.

In addition, the conferees agreed to allocate $87.5 million of the total $1.85 billion to the Community Services Administration (CSA) to support the energy crisis intervention program (ECIP), formerly the energy crisis assistance program (ECAP). The ECIP program, administered by local community action agencies, provides goods and services to low-income households in weather-related emergency conditions. This program, the original energy assistance program for the low-income established in 1976, is intended to complement the Home Energy Assistance Act which provides only for cash assistance to the resident. However, the program will be smaller-scale than in the past several years when the funding level was $200 million. The 1981 amount of $87.5 million will be distributed to the States by the same formula as the Home Energy Assistance Act.

Based on the allocation formula approved by conferees under the continuing resolution (Public Law 96–536), States will receive the following amounts for the Home Energy Assistance Act and the energy crisis intervention program:

	HHS	CSA	Total State allocation
Alabama	$15,076,782	$597,415	$15,674,198
Alaska	9,623,855	381,344	10,005,199
Arizona	7,291,310	288,917	7,580,227
Arkansas	11,504,297	455,856	11,960,153
California	80,882,545	3,204,959	84,087,504
Colorado	28,201,219	1,117,469	29,318,688
Connecticut	36,789,478	1,457,778	38,247,256
Delaware	4,883,091	193,492	5,076,583
District of Columbia	5,713,468	226,395	5,939,864
Florida	23,855,973	945,289	24,801,262
Georgia	18,861,795	747,396	19,609,191
Hawaii	1,899,493	75,267	1,974,760
Idaho	11,000,348	435,887	11,436,235
Illinois	101,876,954	4,034,878	105,861,832
Indiana	46,104,377	1,826,879	47,931,256
Iowa	32,674,799	1,294,734	33,969,533
Kansas	15,005,729	594,600	15,600,328
Kentucky	23,992,570	950,702	24,943,272

	HHS	CSA	Total State allocation
Louisiana	15, 413, 687	610, 765	16, 024, 452
Maine	23, 833, 718	944, 408	24, 778, 125
Maryland	28, 169, 247	1, 116, 202	29, 285, 450
Massachusetts	73, 591, 153	2, 916, 039	76, 507, 192
Michigan	96, 675, 763	3, 830, 763	100, 506, 526
Minnesota	69, 649, 410	2, 759, 848	72, 409, 258
Mississippi	12, 925, 992	512, 191	13, 438, 183
Missouri	40, 673, 651	1, 611, 687	42, 285, 339
Montana	12, 902, 720	511, 268	13, 413, 988
Nebraska	16, 158, 946	640, 296	16, 799, 242
Nevada	3, 424, 511	135, 696	3, 560, 206
New Hampshire	13, 929, 307	551, 947	14, 481, 254
New Jersey	36, 317, 949	2, 707, 089	71, 025, 038
New Mexico	9, 128, 213	361, 704	9, 489, 916
New York	223, 068, 441	8, 839, 054	231, 907, 495
North Carolina	33, 243, 961	1, 317, 287	34, 501, 248
North Dakota	14, 016, 247	555, 392	14, 571, 639
Ohio	90, 081, 158	3, 569, 453	93, 650, 611
Oklahoma	13, 858, 652	549, 147	14, 407, 799
Oregon	21, 857, 131	866, 086	22, 723, 217
Pennsylvania	119, 820, 643	4, 747, 875	124, 568, 518
Rhode Island	12, 113, 523	479, 997	12, 593, 520
South Carolina	11, 974, 035	474, 469	12, 448, 504
South Dakota	11, 383, 649	451, 075	11, 834, 725
Tennessee	24, 303, 957	963, 041	25, 266, 998
Texas	39, 688, 375	1, 572, 646	41, 261, 021
Utah	13, 105, 171	519, 290	13, 624, 462
Vermont	10, 440, 512	413, 704	10, 854, 216
Virginia	34, 313, 289	1, 359, 659	35, 672, 948
Washington	35, 951, 971	1, 424, 592	37, 376, 563
West Virginia	15, 877, 699	629, 151	16, 506, 851
Wisconsin	62, 694, 479	2, 484, 260	65, 178, 739
Wyoming	5, 247, 030	207, 913	5, 454, 942
Total	1, 753, 022, 273	69, 463, 251	1, 822, 485, 524

III. THE LOW-INCOME WEATHERIZATION PROGRAM

The erratic history of the low-income weatherization program continued in 1980. This program, designed to provide weatherization and insulation to the homes of the low-income, began in 1974 with the enactment of the original Community Services Administration (CSA) program under the Economic Opportunity Act (Public Law 88–452). In 1976, additional authority for a similar program under the Federal Energy Administration (FEA), was included in the Energy Conservation and Production Act (Public Law 94–385). During 1977 and 1978, the two programs operated concurrently, each with separate funding and regulations. In 1979, the authorizations for both programs continued, but only the FEA program was funded because of pressures from the administration to consolidate all energy-related programs within the new Department of Energy.

In February 1980, the Senate passed the Economic Opportunity Amendments of 1979 (S. 1725). This legislation substantially expanded the scope and funding levels for the low-income weatherization program.[10] Although slanted toward authority under CSA, the bill left it up to the administration to decide whether CSA or DOE should have jurisdiction.

The House of Representatives counterpart to the Senate bill (H.R. 6619) stalled when it ran into committee jurisdictional battles among three committees. Although reported by the House Education and Labor Committee on May 13, 1980, the bill was never reported by the

[10] For a detailed description of S. 1725, see U.S. Senate Special Committee on Aging report, "Developments in Aging: 1979," part 1, chapter IV, p. 111.

Banking, Finance and Urban Affairs Committee or the Interstate and Foreign Commerce Committee. It died with the closing of the 96th Congress.

However, an authorization for a low-income weatherization program in 1981 was approved by Congress.

Adding to the confusion over jurisdiction between CSA and the DOE, the Congress, as a part of the Energy Security Act of 1980 (Public Law 96–294), commonly referred to as the "Synfuels Bill," approved a 1-year reauthorization of the DOE's weatherization program. The legislation extends the authority under the Energy Conservation and Existing Buildings Act, but makes several changes.

The new law repeals the priority given to community action agencies for administering this program at the local level. The priority provision is replaced with language allowing local management by community action agencies or other public, nonprofit entities with "experience and performance in weatherization or housing renovation activities, experience in assisting low-income persons in the area to be served, and the capacity to undertake a timely and effective weatherization program. . . . In making such selection, preference shall be given to any community action agency or other public or nonprofit entity, which has, or is currently administering an effective program under this title or under title II of the Economic Opportunity Act of 1964."

The 1-year extension reduces the emphasis on utilizing volunteers and Comprehensive Employment and Training Act (CETA) workers for manpower for the program by allowing the Secretary of Labor to raise from $800 per dwelling to $1,600 the amount available to cover the costs of paying persons who install weatherization materials in areas where there are insufficient volunteers and CETA workers to perform such tasks. The law also allows the hiring of qualified workers for conducting specific weatherization activities which require special skills.

In addition, the new law increases the limit per dwelling from $100 to $150 for incidental repairs as may be necessary to make weatherization efforts effective.

To support the 1-year extension, Congress approved $181.9 million for the program in 1981 as a part of the Interior and Related Agencies Appropriations Bill (Public Law 96–514).

The new 1-year authorization only supports the low-income weatherization program through fiscal year 1981. Thereafter, the 97th Congress must decide whether to authorize the program under DOE or CSA. If both programs are continued, the Appropriations Committees will determine which program to support.

IV. THE HEAT WAVE OF THE SUMMER OF 1980

The summer of 1980 witnessed record high temperatures for record long periods of time. Continuing severe heat, which exceeded 100° in 10 States for at least a month, was blamed for the deaths of approximately 2,000 persons. The majority of the dead were elderly; thousands more senior citizens were hospitalized.

On July 25, 1980, the U.S. Senate Committee on Aging and the Senate Subcommittee on Aging of the Labor and Human Resources

Committee called an emergency hearing to hear from representatives of the affected States and to discuss with the administration the effectiveness of Federal programs attempting to respond to the crisis.

Senator Thomas F. Eagleton (D.-Mo.), cochairman of the hearing, pointed out:

> The severity of the 1977–78 winter made us all aware that adequate home heating is a necessary aspect of shelter; lack of heating poses a very real threat to health and safety. This summer's searing heat wave, which has held Midwestern and Southern States in its stranglehold for more than 1 month, has tragically demonstrated that air-conditioning, too, can be a life and death matter.[11]

Senator Lawton Chiles (D.-Fla.), the other cochairman pointed out:

> The committee has learned from the National Institute on Aging that older persons are far less able to adjust their body temperatures to extreme heat and cold, and therefore, are in far greater danger of being exposed to weather-related illnesses and death. We have learned from the U.S. Surgeon General that heat is particularly dangerous for persons suffering from chronic conditions such as heart disease, blood pressure, and respiratory illnesses. One or more of these conditions often afflict our older citizens.[12]

Representatives of programs which serve the elderly reinforced statements of the chairmen. An area agency on aging director from Arkansas described for the committees what happened in Arkansas during the heat wave:

> Inflation-eroded incomes may be totally insufficient to support even a $5-per-month utility bill increase. Living on $238—SSI—per month takes careful management.
>
> Many elderly are too frail to raise their windows.
>
> Some have had their homes weatherized for winter and their windows are permanently puttied shut. Or they are afraid to remove plastic weatherstripping for fear of being unable to afford replacement cost when bitter cold winter weather returns.
>
> Some elderly have air-conditioners, but do you think they are plugged in? Absolutely not. Who is going to pay the utility bill?
>
> And most important of all, many of the elderly had rather die than leave home. Thus, in spite of 24-hour emergency heat shelters located in senior centers throughout the State, we go in their homes and find them—dead.[13]

Similar cases were reported by a service provider from Missouri. She explained:

> For people in fair health, able to take care of themselves, the heat was uncomfortable and inconvenient; for the frail

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[11] U.S. Senate Committee on Aging and the Subcommittee on Aging of the Labor and Human Resources Committee; joint hearing on "Energy Assistance and the Elderly (Impact of the 1980 Heat Wave)," July 25, 1980, Washington, D.C., p. 2.
[12] Ibid, pp. 1 and 2.
[13] Ibid., p. 22.

elderly it was deadly. These are the individuals who have difficulty coping with the usual tasks of daily living, and the added demands of coping with the heat are simply beyond their capacity. They could not go to a cooler place, they could not go out and buy a fan, they could not move their beds to a cooler spot unless someone helped them. They did not survive.

It is important to keep that fact in mind as we look at ways to deal with a heat wave. It is primarily a problem of the elderly and the assistance provided must be geared to the characteristics of the elderly. Essentially, the assistance was directed to two approaches—to change the immediate environment of the older person to make it a more livable environment, or to change the person to a more livable environment.[14]

Responding to the crisis needs of victims in States affected by the heat wave were a variety of Federal, State, and local programs. However, the Federal energy crisis assistance program (ECAP) under the Community Services Administration (CSA) and the Home Energy Assistance Act administered by the Department of Health and Human Services (HHS) were responsible for providing approximately $30 millions of unspent 1980 fiscal funds to those States who met new standards prescribed for the crisis. Distribution of the identified unobligated 1980 funds was more difficult than usual because of a restriction placed on the 1980 energy assistance funds for use beyond June 30, 1980. This restriction, as Assistant Director of the Community Services Administration Michael Blouin told the committee, came from the House of Representatives Appropriations Committee which "conceived of this (program) as a special emergency heating program and was concerned that it not evolve into an indefinite entitlement program." [15]

To resolve this complication and allow funds to be more expeditiously distributed during the summer, several bills were introduced to remove the June 30 prohibition.[16] Immediate action was taken on a measure sponsored by Senators Bentsen, Chiles, and Domenici (S. 2995), which allowed the CSA to obligate funds beyond the June 30 deadline and transfer funds from other programs. This measure was signed by the President immediately (Public Law 96–321), giving more flexibility to agencies and States to serve the needs of heat wave victims.

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[14] Ibid., p. 29.
[15] Ibid. p. 48.
[16] S. 2966, S. 2968, S. 2978, and S. 2995.

Chapter 6

SOCIAL SERVICES

CHAPTER HIGHLIGHTS

In the 15 years since the enactment of the Older Americans Act of 1965, the overall goal of the act—making services available in communities throughout the 57 States and Territories—has been achieved. Therefore, the focus of the 1978 amendments was management efficiency, both fiscal and programmatic.

The amendments, requiring major changes in the national network on aging, provided a 2-year transition period—fiscal years 1979 and 1980. The transition was accomplished in two phases: The promulgation of regulations to implement both title III, State and community programs, and title VI, direct funding for Indian tribal organizations, was completed in phase 1. Implementation of the regulations requiring multiyear State and area plans, mechanisms for providing services and resolving complaints in long-term care facilities and the transfer of payment for community-based supportive services from nutrition funding to social services funding, etc., comprised the second phase.

A multiyear strategy for discretionary programs, title IV, was developed by the Administration on Aging (AoA) in 1978. Since that time, discretionary activities have focused on the following four categories:

—The social integration of older people through policy development and advocacy.
—Serving those in need.
—Long-term care; and
—Improving capacity through application of knowledge.

This multiyear strategy for discretionary programs was the AoA's response to the demographic changes brought about by declining birth rates, extended longevity, changing role of families, and increasing demands for a wider range of community-based services.

Fiscal year 1980–81 appropriations provided modest increases for OAA programs. Additional funding was necessary for States to comply with the expanded mandates of the 1978 amendments. These mandates included direct grants to Indian tribes, federally funded home-delivered nutritional services, State-administered long-term care ombudsman programs and the consolidation of nutrition and social services under one title.

ACTION's established older Americans volunteer programs—foster grandparent, senior companion, and retired senior volunteer programs—saw modest growth in the 1980–81 period. These programs

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serve the dual purpose of combining the talents and experience of older persons with unmet community and individual needs. Special emphasis is placed on serving the ill, the isolated elderly, and youth who are emotionally or physically disabled.

Congress authorized ACTION to design two new programs to benefit the elderly during fiscal year 1981—fixed income consumer counseling, and helping hand. Although these programs are responsive to persons of every age, the majority of persons helped by both programs are the elderly.

Following 6 years of a congressionally imposed ceiling of $2.5 billion for social services under title XX of the Social Security Act, Congress passed a 1-year only increase in the ceiling in 1978 and authorized future growth by indexing the ceiling with the Consumer Price Index for the next 6 years.

As a result of this legislation, Federal matching grants to States were authorized at $2.7 billion in fiscal year 1980 and $2.9 billion in fiscal year 1981. Services most frequently offered through title XX State plans include day care, homemaker, counseling, and protective services.

The 1978 reauthorization of the Comprehensive Employment and Training Act of 1973 (CETA) provided a greater focus on the employment problems of older workers. The Secretary of Labor was directed to insure that prime sponsors' plans contain procedures for making services available to individuals who are experiencing handicaps in obtaining employment, including those who are 55 years of age and older. Despite the mandates of the CETA legislation, and the assertions by the Department of Labor (DOL) that persons of all working age groups participate in activities under CETA, Congress continues to express concern that the CETA program has not been responsive to the needs of older workers.

Debate over the accessibility of mainline bus and rail systems to the handicapped was rekindled in 1980. Separate measures that would have authorized transit authorities to submit a plan to the Department of Transportation for meeting the needs of the handicapped through specialized transportation services were approved by both the House and Senate. However, in the final days of the 96th Congress, when a compromise could not be reached to reconcile the differences between the two Houses, both measures died.

I. THE OLDER AMERICANS ACT

A. Overview

The Older Americans Act (Public Law 89–73) was first enacted by the 89th Congress in 1965 and amended in 1967, 1972, 1973, 1974, 1975, 1977, and most recently in 1978.

Several major objectives were stated by Congress when the act was passed in 1965:

—The formulation of an Administration on Aging to act and speak on behalf of older persons at the Federal level.

—The development of community-based programs to deliver vitally

needed social services to help older persons live independently in their own homes.

—The operation of research and demonstration programs to test innovative ideas; and

—The availability of training grants to provide skilled personnel as programs on aging increased in scope and number.

Although Congress has amended the 1965 act a number of times, it is clear that the major objectives of the act have never changed and that revisions are intended to strengthen and clarify the original intent of the act.

From 1965 to 1972, the Older Americans Act (OAA) was a fledgling program, struggling in most States and communities to obtain local matching funds in order to utilize the Federal funds available to develop programs for older persons. The OAA program began in 1965 with an initial appropriation of $6 million and grew to $33 million in 1971.

The big gain for the OAA, and possibly the action which saved it from an administration movement to abolish it, was the 1971 White House Conference on Aging. The 1971 Conference brought forth a host of recommendations. The one which drew the most attention, from both the White House and the Congress, was a recommendation to fund a national nutrition program. The nutrition program was to be patterned along the lines of 31 demonstration projects which had tested a variety of approaches for nutrition programs for the elderly. These demonstrations had been funded in the late 1960's under the research and demonstration authority of the act.

The nutrition program, enacted in 1972 as title VII of the act (Public Law 92–258), received an appropriation of $100 million for fiscal year 1973. With this new, and visible program, and a total fiscal year 1973 budget of $253 million, the OAA was legitimized as a major piece of social legislation. Consequently, both elected officials and service providers began to examine the legislation and to compete for funding under the act.

The 1973 Older Americans Comprehensive Services Amendments (Public Law 93–92) authorized a major restructuring of the act. These amendments introduced a new concept by mandating the establishment of a nationwide network of substate or area agencies on aging. The objective of the area agency concept was to provide for a better organizational structure at the State and substate levels, and to provide better planning and coordination of resources at the substate or local levels.

The 1973 amendments required States to divide the State into separate areas, "planning and services areas" (PSA's), for the purpose of developing a plan for the establishment of a comprehensive and coordinated system of services to older persons. The State was then required to designate an agency within the PSA as an area agency on aging. This area agency would be responsible for the development and implementation of the comprehensive plan. Although States were urged to designate area agencies, and an incentive was provided for funding of programs under the jurisdiction of area agencies, area agency designation did not become mandatory until the 1978 amendments.

Title V, multipurpose senior centers, also became a part of the act in 1973. This title authorized grants for establishing and operating multipurpose senior centers to serve as a focal point for the delivery of services in each community. Such grants would provide up to 75 percent of the cost of acquiring, altering, or renovating facilities to serve as centers. However, no funds were appropriated for this title until fiscal year 1977 when the first appropriation of $20 million was used to establish or renovate over 500 senior centers.

The 1973 amendments also provided authority for the community service employment programs—title IX. This program provides part-time jobs to low-income individuals aged 55 or over and was modeled after a Department of Labor demonstration program, operation mainstream, which had been funded in 1965 under the Economic Opportunity Act. In the 1978 reauthorization of the OAA, the community services employment program for older Americans became title V, the formula for allocating funds was changed, and the Department of Labor was instructed to use its coordination authority to insure that an orderly placement of job slots be realized within each State.

A minor change in the 1973 amendments combined the separate research and training authority titles of the act into a single title, title IV. Congress took this action to reflect the close interrelationship of training and research and development, and to reemphasize the importance of utilizing the limited funds allocated to this title for the ultimate benefit of future service programs.

This brief overview of the history and development of the OAA provides a basis on which to evaluate and understand the scope of change required by the 1978 amendments, the reasons why Congress considered those changes necessary, and the time period required by State and area agencies to implement fully the changes required by the amendments.

As previously mentioned, no major changes were made in the act from 1973 to 1978. During that 5-year period, a network of more than 600 area agencies had been developed, approximately 2,500 nutrition sites were serving meals from 1 to 5 days per week, and greater responsibilities and roles had been mandated for both the State agencies on aging and the AoA. Congress became increasingly concerned about problems involved in administering the programs, including the fragmentation of programs and services which were intended to serve all older persons; the not infrequent inability of the AoA to manage effectively the Federal appropriations provided for the AoA, and problems with effective coordination of AoA with other Federal agencies providing varied services to older persons. The OAA was considered to be a federally funded, State-administered and locally operated program. However, the employment program, title V, was implemented by the Department of Labor with little or no coordination with the AoA or the national network on aging. The multipurpose senior center funding was directed through the State offices on aging rather than the area agencies, as was the procedure for other title III funding. In many States, the nutrition program was funded directly from the State offices on aging to a multitude of nutrition projects. Priorities for services were being established by Congress rather than being based on needs assessments by local service providers.

Upon careful examination of the demands and responsibilities placed upon the AoA, and the State and area agencies by the various modifications to the original legislation, the 95th Congress determined that the overall goal of making services available in every community throughout the 57 States and Territories had been achieved, that it was time to consolidate various components of the program in the interest of more effective and efficient management. The focus of the 1978 amendments was efficiency in management, both programmatic and fiscal. Seeking to avoid further fragmentation, Congress took action to consolidate existing services and stressed throughout the amendments that there should be a greater degree of coordination among programs serving older people administered by other Federal, State, or local agencies.

A review of the major changes affected by the 1978 amendments may be appropriate at this juncture before examining how the AoA has implemented the changes or the accomplishments and benefits derived from the legislative changes. The significant changes required by the 1978 amendments include the following:

1. COORDINATION

The AoA was given additional responsibilities for coordinating non-Older Americans Act programs affecting the elderly.

2. ADVOCACY

The AoA, along with State and area agencies, was provided specific advocacy responsibilities. For the first time, the advocacy role was explicit in the 1978 legislative provisions.

Each State must develop a State-administered long-term care ombudsman program.

3. ORGANIZATION AND MANAGEMENT

State and area plans will cover 3-year periods.

State plans will be based on area plans.

Each State must develop an intrastate formula for distributing title III–B and title III–C funds (social service and nutrition funds).

Area agencies are required to provide program planning and management responsibilities for all title III–B and title III–C programs.

4. SERVICES

State agencies were given responsibilities for serving patients in long-term care facilities.

Area agencies were required to spend at least 50 percent of their title III–B allotment on the following priority services:

—Access services, including transportation, information and referral, and outreach.

—Legal services.

—In-home services (homemaker and home health aide, visiting and telephone reassurance, and chore maintenance).

—A separate and expanded authority for home-delivered meals.

5. TARGET OR SPECIAL POPULATIONS

Explicit recognition was given to the need to "provide a continuum of care for the vulnerable elderly" under title III.

State and area agencies were directed to give preference in the delivery of services to the elderly with the "greatest economic or social need."

States were directed to expend additional funds in rural areas, above the amounts expended in fiscal year 1978, unless the requirement was waived by the AoA.

6. NATIVE AMERICANS

Title VI was authorized to provide direct grants to qualified Indian tribal organizations for social and nutritional services to Native Americans age 60 or older.

B. Transition Period for 1978 Amendments

The 1978 amendments authorized a 2-year transition period, fiscal years 1979 and 1980, during which time both the AoA and State agencies could waive certain requirements of the act. However, all provisions of the amendments were to be fully implemented no later than the beginning of fiscal year 1981—October 1, 1980. This transition period actually had two phases: The first year—fiscal year 1979 until March 1980—was utilized by the AoA for the development of final regulations to implement title III; the second year—fiscal year 1980—was the period in which the first multiyear State and area plans were developed and the transfer of funding for supportive services for the nutrition program from title III–C to title III–B was completed.

C. 1980—The Final Year of Transition for the 1978 Amendments

Although the 1978 amendments to the OAA were signed into law effective October 1, 1978, regulations necessary to implement fully the major provisions of these amendments (title III, grants for State and community programs on aging) were not promulgated by the end of 1979. Considerable concern, which later turned to alarm, was expressed both to the AoA and the Department of Health and Human Services (HHS) regarding the lengthy delay in publication of the OAA regulations. Proposed regulations were published by the AoA on July 31, 1979 (vol. 44, Federal Register, p. 45032). The AoA distributed over 100,000 copies of the proposed regulations, held 11 public hearings, received testimony from more than 400 witnesses and written statements from an additional 1,600 individuals. The Commissioner on Aging was the sole witness at a joint hearing of the Senate Subcommittee on Aging of the Labor and Human Resources Committee and the Special Committee on Aging (October 18, 1979), to explain the delay and to discuss several controversial issues which emerged from the proposed regulations during the mandatory 60-day public comment period.

Senator Lawton Chiles, chairman of the Special Committee on Aging, and Pete V. Domenici, ranking minority member on the committee, formally requested a status report from HHS Secretary

Patricia Roberts Harris and her support and assistance in expediting publication of the final regulations. Staff of the Special Committee on Aging reviewed the hundreds of written responses forwarded to the committee from the national network of aging agencies, along with many of the responses provided directly to the AoA, and determined that there was consensus throughout the aging network as to the areas of concern in the proposed regulations. The Commissioner on Aging, Robert C. Benedict, was questioned at the October 18, 1979, hearing about these issues. Senators attending this hearing expressed grave concern that the AoA was not following congressional intent in the development of the regulations and questioned the differences between the perceptions of Congress, the State, and area agencies and local service providers, versus the views of the AoA on the following issues:

—Single organizational unit (to administer the OAA program at State/substate levels).
—State and area agency resource allocation plan.
—State plans review, and the roles of the State Advisory Council and the A–95 review agency.
—Hearings procedures.
—The types of agencies that may be designated as area agencies.
—Service requirements for multipurpose senior centers.
—The relationship between providers of home-delivered and congregate meals programs.
—The options for determining "greatest economic need," "social need," and "rural area."
—Congressional intent relative to the establishment of community focal points; and
—Redesignation of service areas (PSA's) and area agencies on aging.

When the long-awaited final regulations were published on March 31, 1980 (vol. 45, Federal Register, p. 21126), the controversial issues had been resolved with the exception of the single organizational unit issue. The regulations almost completely removed the administrative requirement for a single organizational unit at the State level by permitting States to request waivers from the Commissioner on Aging. States were also provided authority to grant similar administrative waivers to area agencies.

While this issue was resolved to HHS's satisfaction, there was considerable concern both in Congress and the national aging network, that the position taken by the Commissioner on Aging would weaken the role of both the State and area agencies on aging at a time when they needed guidance to meet increasing demands for service caused by growing numbers of older persons and double-digit inflation.

D. 1980—Implementation of the 1978 Amendments

With the 1978 amendments and the final regulations, the role of State and area agencies had been expanded in the following ways:

—States were required to target social services to those older persons with the greatest economic or social need but not to set specific individual eligibility requirements. Factors such as physical and mental disabilities, language barriers, and cultural or social isolation were to be considered when selecting social service sites.

Economic need was defined as the poverty income level established by the Bureau of the Census.

—Area agencies on aging were allowed to directly fund providers of home-delivered nutrition services rather than solely through congregate nutrition projects, as proposed in the draft regulations.

—The statutory requirement for a comprehensive community-based system of services for older persons was reinforced by the regulations. The States were also required to establish long-term care ombudsman programs to investigate complaints of nursing home and adult care home residents.

—Administrative reforms which would reorganize service delivery and authorize 3-year State and area agency planning cycles was stipulated in the regulations.

—Consolidated authority to administer programs under area agencies on aging was provided in the regulations, along with an expanded role for citizen advisory boards and increased community responsibility for planning and administering all OAA programs.

—Both the law and regulations required area agencies on aging to designate community focal points for the colocation of services for older persons in communities and neighborhoods. The final regulations underscored the statutory requirement that needy elderly receive services by requiring that 50 percent of each area agency's service budget be allocated to provide access services, in-home services, and legal services.

The first 3-year State plans to include all of the requirements contained in both the 1978 amendments and the subsequent regulations, were submitted in mid-1980 and went into effect on October 1, 1980.

E. Title III–B and Title III–C—Changes Continue in 1980

Title III–B of the OAA provides the funding for all community services. These funds flow from the AoA through the national aging network, which consists of 10 regional offices, 57 State and territorial offices on aging, 635 area agencies on aging, 4,204 senior centers, 1,185 nutrition projects with 12,556 different meal sites. Title III funds are distributed to the States by a congressionally mandated formula based on the population of older people in each State. In turn, States allocate service funds to area agencies using an intrastate funding formula, which was mandated by the 1978 amendments.

Title III administrative funds, $22.5 million in fiscal year 1980, support the State agencies to assure proper and efficient management of State plans, fiscal control and accounting procedures, and a process to determine which existing private and public programs meet the needs of the State's older residents.

Title III–B social service funds are used to pay up to 85 percent of the cost of operating and establishing a network of community services and multipurpose senior centers. Area agencies fund the network of community services within their PSA, in accordance with the State approved area plan. These services include activities in four basic categories: Access services, in-home services, community and neighborhood services, and services to residents of care-providing in-

stitutions. Access services are defined as outreach, and information and referral services. Homemaker and home health aide, visiting and telephone reassurance, and chore maintenance comprise the in-home services. Legal services, residential repair and renovation, acquisition, alteration, renovation and construction of facilities to serve as multipurpose senior centers, are included in the community and neighborhood services category. Additional services in this category are the services designed to meet the unique needs of older individuals, including the services of an ombudsman to receive, investigate, and act on complaints by older individuals who are residents of long-term care facilities; and services which reduce the risk to residents of such facilities and develop or expand opportunities for alternative living arrangements. Authority to provide services to individuals in long-term facilities was provided in the 1978 amendments. The year of transition, fiscal year 1980, revealed the first developing links between community-based services and service to institutionalized individuals.

Title III–C, the nutrition and home-delivered meals section of the OAA, receives the largest single allocation of financial support ($320 million in fiscal year 1980) and is the most visible, and often, the only component of the OAA known to elected officials and older persons. AoA has struggled for years to make the nutrition program more than a meal program. Funds from this title are awarded by formula grants to each State with an approved State plan to pay up to 90 percent of the cost of establishing and operating nutrition services. These funds are combined with other Federal resources and State and local resources to provide both meals and supportive services at over 12,000 nutrition sites across the Nation.

Most of the nutrition sites provide a variety of services and activities in addition to nutritious meals. These sites are under the leadership of trained personnel. Many older persons themselves are paid employees or volunteers at these sites. Since the nutrition site is often the older person's first contact point with other needed services, the "supportive services" component of the site may offer nutrition education, health screening, transportation, and information about community services and benefits, along with meals and social and recreational activities.

The 1978 amendments provided a separate and expanded authorization for home-delivered meals. The appropriation for the home-delivered nutritional services was $50 million in fiscal year 1980, with statutory authority to transfer funds between the congregate and home-delivered meals programs. The regulations authorize States to transfer 15 percent or less of funds between separate allotments for congregate and home-delivered meals without prior approval from the Commissioner on Aging. The Commissioner's approval is required when a State agency wishes to transfer more than this amount. The Commissioner would approve the State agency's request by approving the State plan or plan amendment. Within the constraints imposed by the State plan, the percentage of nutrition funds to be spent for meals in congregate or home-delivered programs is at the discretion of the project operators. Some projects, particularly those in rural areas, may find that the needs of elderly persons in their PSA can best be met through an expanded home-delivered program.

F. Title IV—A Multiyear Strategy for Discretionary Programs

The title IV research, training, and demonstration projects support the basic goals and functions of the Older Americans Act programs. These provisions, articulated in title II of the act, have been aggregated by the AoA into four primary areas of responsibility. These areas, the basis upon which the discretionary programs have been developed since 1978 include: (1) The social integration of older people through policy development and advocacy; (2) serving those in need; (3) long-term care; and (4) improving capacity through application of knowledge.

1. POLICY DEVELOPMENT AND ADVOCACY

The 1981 White House Conference on Aging (WHCOA) scheduled November 30 through December 1, will provide an opportunity for older Americans to help in the formulation of national policies which affect older persons. The Conference is charged with producing a final report which expresses a "comprehensive coherent national policy on aging together with recommendations for implementation of the policy." In support of the discretionary projects goal of social integration of older people through policy development, during 1980 the AoA provided funds for seven Mini-White House Conferences in special areas, 51 State conferences, and four regional WHCOA hearings.

The AoA has also provided a forum for national policy review in areas of national policy significance through national policy review and development conferences. The objectives of these conferences are:

—To review and integrate research findings.
—To review current practice.
—To disseminate knowledge.
—To stimulate best practice replication in the public and private sector; and
—To provide new policy and program options.

Each of the conferences involved the following steps:

—Identification of policy questions and problems.
—Preparation of policy background papers.
—Review and critique by invited experts; and
—Submission of reports and recommendations to AoA.

AoA chose to use these conferences as a vehicle by which a Federal agency can assemble the most knowledgeable individuals in and out of government to examine major social policy problems of immediate- and long-range importance. During 1980, the AoA funded 13 such conferences focusing on varied issues to include age discrimination, long-term care, older women, abuse or neglect, and business and industry.

Also in support of the development of policy alternatives, the AoA funded national aging policy centers. The purpose of these centers, the majority of which are based in academic institutions, is to provide interdisciplinary analytic approaches for six policy areas. The areas of concentration and their locations are:

—Income maintenance, Brandeis University.
—Housing and living arrangements, University of Michigan.
—Employment and retirement, University of Southern California.

—Education, leisure, and continuing opportunities for older persons, the National Council on Aging, Washington, D.C.
—Older women, the University of Maryland; and
—Health care for the aging, University of California at San Francisco.

These national aging policy centers have been charged with the responsibility of aggregating and synthesizing both AoA and non-AoA research and demonstration findings for use as follows:

—Introduction of research findings into teaching curricula.
—Defining future research agendas; and
—Incorporation of findings into governmental programs, and examination for policy implications.

The AoA's support for advocacy was an outgrowth of the 1978 amendments which established State and area agencies as advocates for older persons. The OAA also requires that every area agency on aging spend "some funds" under title III for legal services. AoA has implemented its services mandate in part by attempting to meet the legal needs of older persons by counsel and representation in order to protect their rights and assist in obtaining benefits and entitlements. These rights include the rights to public benefits, pensions and other retirement income; rights to employment without age discrimination; rights to housing and health care; rights of institutionalized older persons; and rights to alternatives to institutionalization.

Each State is now mandated to have a State-administered long-term care ombudsman program. The ombudsman program must provide the following services:

—Investigate and resolve complaints made by or on behalf of older individuals who are residents of long-term care facilities.
—Monitor the development and implementation of laws, regulations, and policies with respect to long-term care facilities in that State.
—Provide information as appropriate to public agencies regarding the problems of older individuals residing in long-term care facilities; and
—Train volunteers and promote the participation of citizen organizations to participate in the ombudsman program.

During 1980, AoA promulgated regulations to implement the advocacy, legal services, and ombudsman programs. The agency also chose to use part of its discretionary resources to implement these requirements. Each State agency received a grant to give priority to developing long-term care ombudsman programs and to improving legal services for the elderly. States were to use these discretionary grants for the following purposes:

—To encourage the interrelationship of the ombudsman and legal services programs and improve their coordination.
—To assure more legal support for the ombudsman program, especially in dealing with the problems of the institutionalized elderly; and
—To encourage the increased use of advocacy by nonlawyers to serve older persons.

Five bilingual advocacy assistance support centers were funded by the AoA to help the States meet their mandate to advocate for older persons, expand legal services, and implement the long-term care om-

budsman program. These support centers provide materials, research, and legal counsel to the national aging network. Staff for the centers are experienced lawyers and paralegals who design and deliver materials and train and support all States in their regions. In the fiscal year 1980 work plan and contract to fund this plan, the AoA suggested that the work of the centers should include:

—Holding training conferences for State legal services and ombudsman personnel to provide them assistance in substantive areas such as medicare, food stamps, and age discrimination.
—Helping States design statewide training programs for advocates, and training trainers in each State.
—Providing counseling and materials on service delivery systems, including model contracts, evaluation instruments, and funding proposals; and
—Providing analysis of law reform issues and assistance in pursuing law reform litigation and other remedies for elderly clients in the courts.

The 1978 amendments to the OAA made a change with respect to legal services to the elderly by requiring that legal services be added to priority services for which at least 50 percent of the area agencies' title III–B funds must be spent, and by requiring that no less than $5 million appropriated under section 451 of the act be used directly for legal services or to facilitate the provision of such services. AoA met this mandate in 1980 with the following efforts:

—Grants to State agencies to provide specialized staff to develop and support legal ombudsman services in each area agency in the State.
—Biregional advocacy assistance centers to provide specialized training and technical assistance to each State and area agency legal and ombudsman program; and
—Grants to develop training materials and research materials on areas of law of particular concern to the elderly.

2. SERVING THOSE IN NEED

The second part of AoA's evolving discretionary grants strategy is devoted to the goal of "serving those in need." AoA devoted some fiscal year 1981 resources to this concept and funded projects to accomplish the following:

—Improve community-based services.
—Strengthen family support.
—Reach out to minorities; and
—Address special populations and special problems.

Since older persons are very dependent on the neighborhood and the community for meeting basic needs, AoA undertook several studies to estimate the number and characteristics of special retirement communities, and to examine problems of older people in neighborhoods undergoing revitalization. These studies include an endeavor by the National Council on Aging to develop models for senior centers; projects by the Waxter Center in Baltimore, and the Jamaica Service Center in New York to develop models for providing services for the disabled at senior centers; and the operation of an experimental day care center program for the at-risk elderly by a northern Kentucky agency.

Since older people report problems in securing adequate health care, and area agencies indicate that health care is one of the most frequent requests of older people, AoA funded six research and model projects across the country to promote "self-help wellness" and health promotion for persons over age 75. Two of these studies are charged with examining and improving in-home care in conjunction with an HHS-wide long-term care program: Brandeis University is examining several issues in home care including the effectiveness of care planning, whom providers select, and the cost of services provided; the Benjamin Rose Institute is studying the effects of care giving on families who care for older people in their homes.

The 1978 amendments authorized State and area agencies to use title III–B funds to provide services to older people residing in foster homes, housing facilities, domiciliary care, and nursing homes. AoA, consequently, is supporting a number of efforts to expand the supply, and improve the services available, to older people residing in such facilities. For example, over 1,000 nutrition sites are colocated in public and special housing settings and an effort is underway whereby AoA and the Farmer's Home Administration (FmHA) are developing model congregate housing projects for older persons. FmHA funds are being used to construct the facilities, while AoA funds are used to assist area agencies on aging to support the service components of those facilities. This is a 3-year demonstration project for which FmHA has allocated $10 million in resources and AoA, $2.55 million.

In the area of strengthening family support, AoA has funded five research projects and eight demonstration projects to work directly with the problems associated with assisting the family as the primary care giver. Research is being conducted on older people as self-help care givers, the use of high school students as care givers, measuring intrafamily transfers, and the impact of service providers on family networks.

The eight model projects awarded in this category include a project to develop and disseminate training materials directed at assisting adult children to better care givers. Other projects are designing and testing peer support systems and the use of multidisciplinary teams to strengthen efforts of families and friends as care givers in both urban and rural areas.

During 1980, the AoA made a special effort to improve services to minorities. As described in detail below, title VI of the OAA provides direct grants to Indian tribal organizations to provide social and nutritional services comparable to title III services. The AoA conducted a national competition to permit a limited number of area agencies to implement special affirmative action of programs as part of their emphasis on improved service to minorities. Four area agencies were awarded projects. Successful models derived from this experiment will be used by AoA to improve the performance of all agencies providing services to older people. AoA is also conducting six projects targeted at Hispanics as part of an Office of Human Development Services (OHDS) initiative. A final part of this effort on behalf of minorities is the cooperative agreements between the AoA and the following national minority organizations:

—The National Association for Spanish-Speaking Elderly.

—National Center on Black Aged.
—National Indian Council on Aging; and
—The Pacific/Asian Resource Center on Aging.

These organizations work directly with AoA regional offices to assist State and area agencies to improve services to minority communities. From these projects, and other OAA funded research grants, the AoA hopes to significantly enhance knowledge about minority needs and services.

The AoA has also used its discretionary authority and funding to address a number of special problems and special population groups, to wit:

—Five State or area agencies on aging received awards to demonstrate improved methods for service delivery in rural areas.
—A research grant was provided to the American Foundation for the Blind to study adaptive techniques to compensate for sign sensory impairment, and the foundation will produce a handbook describing their work in this area.
—Funds were awarded to three State and area agencies to develop models for meeting the needs of abused older persons.

Limited funding has been provided to improve services to migrants and refugees, to conduct a demonstration project at the Ohio State School for the Deaf, and to help support a number of community hospice projects for the terminally ill.

3. RURAL-URBAN COST DIFFERENTIAL STUDY

In response to an increasing concern about the cost of providing services to the elderly in rural areas, Senator Pete V. Domenici introduced an amendment to the 1978 Older Americans Act during the 1978 reauthorization process to provide increased funds to rural areas through a weighting of the State allotment formula.

Senator Domenici's amendment was passed by the Senate. The conference committee, however, retained the preexisting formula and inserted a new subparagraph (b) of section 307(a)(2) of the act requiring that each State plan provide assurances that the State agency will spend in each fiscal year, for services to older individuals residing in rural areas, an amount equal to not less than 105 percent of the amount spent for such services in fiscal year 1978. During the deliberations on this amendment, conferees realized that information about the differences in needs and existing services, and the comparability of costs of delivering services in rural and urban areas, was not available. Consequently, the conference committee retained a provision, which became a part of the law, directing the Commissioner on Aging to conduct a study related to the differences in unit costs, service delivery, and access between rural areas and urban areas, and the special needs of the elderly residing in rural areas. The law required submission of the report to the Congress no later than October 18, 1980.

As of March 6, 1980, the Administration on Aging had not started the study. This delay was one of the issues addressed by the committee in a hearing on the "Implementation of the Older Americans Act Amendments of 1978," which was chaired by Senators David Pryor and Pete V. Domenici on March 24, 1980.

Subsequent to this hearing, the AoA developed a plan for three phases of the study and began a more intense search for research proposals to fulfill this mandate. An explanation of the three phases and the status of each follows:

Phase I.—A compilation of existing information about unit costs, rural-urban elderly differences in access and services, and the special needs of the rural elderly. AoA planned to accomplish this portion of the study using its staff with the help of consultants. This in-house collection of existing data had not been transmitted to the Congress as of December 31, 1980.

Phase II.—An evaluation study to analyze existing data on rural-urban elderly differences, and to develop a research design for a major field study involving the collection of original data and new information. Phase II of the study will include a review of the relevant literature, an annotated bibliography, a report on rural-urban differences as revealed by the existing literature, and an analysis of existing data. Another product of phase II will be a research design for the field study to gather new information.

The request for proposal for phase II was not issued until September 1980, and the award made to Econometrics Inc., in late January 1981. A final report on the results of this part of the study is expected to be ready for transmittal to Congress by December 1981.

Phase III.—A comprehensive field study of rural-urban elderly services, using the research design developed in phase II. The AoA had intended to release a request for proposal for this study by April 1981. However, since the study design is to be one of the products of the phase II contract, the initiation of this final phase may be further delayed.

No portion of this mandated study was completed by the legislative deadline, and as of December 30, 1980, the AoA had not submitted a status report to Congress explaining the delay. Furthermore, it appeared unlikely that any substantive findings or results would be available for the deliberation on reauthorization of the Older Americans Act in 1981.

4. LONG-TERM CARE

The third component of AoA's discretionary program is long-term care. This past year has brought a concerted effort on the part of AoA to move the agency and national network on aging toward a continuum of care for the functionally disabled. The 1978 amendments to the OAA strengthened AoA's role with respect to the vulnerable, chronically incapacitated elderly. A new section (422) was added to the legislation entitled "Special Projects in Comprehensive Long-Term Care." This section granted the Commissioner authority to make special grants to support the development of comprehensive coordinated systems of community long-term care for older individuals. The key element in the component is "community," and the AoA is devoting substantial dollars and staff resources to the development of truly "community-based" alternatives for the chronically ill or functionally disabled.

Long-term care, in keeping with the intent of the OAA legislation, has been defined by the AoA as health care, social services, or personal

care including supervision, treatment, or minor help with everyday tasks, provided formally or informally on a recurring or continuous basis to functionally impaired individuals. This care is provided in homes or other homelike settings, in the community or in an institutional setting if that is the preference of the client or the medically necessary option.

5. LONG-TERM CARE CENTERS AND FELLOWSHIPS

The AoA determined that current public policies and programs do not provide a reasonably comprehensive and coordinated range of community-based services to individuals in need of long-term care. In an effort to affect these public policies and programs, AoA has funded projects which will begin to build a knowledge-and-practice-base for the future: Long-term care multidisciplinary gerontology centers and geriatric fellowships.

Both the centers and the fellowship programs are expected to expedite the development of staff resources and technology, and also to provide opportunities for basic and applied research in long-term care. The AoA developed these programs in response to the perception that health and medical training and research were oriented to acute problems in an era in which the incidence of chronic illness and functional impairment were rapidly increasing. The determination was made by AoA, in conjunction with experts in the field of long-term care, that a multidisciplinary and interdisciplinary approach was necessary to address properly the problems of chronic illness and functional impairment. This group also agreed that the presence of a Federal effort to establish a basis for multidisciplinary staff development and basic and applied research in the treatment of chronic impairment and functional disabilities was long overdue.

As a result, the multidisciplinary centers were planned with a combined health/social services approach. The centers have a clearly defined relationship both with medical schools and with community-based long-term care service providers. The focus of this program is fourfold:

—To enhance the education and training of medical and social service professionals and paraprofessionals regarding the long-term care needs of the elderly.

—To increase the amount and quality of practice-oriented and policy-relevant research dealing with long-term care problems.

—To facilitate innovation and experimentation in long-term care service delivery in an experimental environment; and

—To disseminate the best practice and knowledge through consultation, technical assistance, continuing education and training, and public information.

The geriatric fellowship program was first funded by the AoA in fiscal year 1979 with six grant awards to support the development of multiyear programs to train 18 future faculty members. These geriatric physicians will become members of medical school faculties for the purpose of training others in geriatric medicine, and supervising and encouraging research and practical experiences related to geriatric care.

A critical part of the AoA's long-term care effort is the national channeling demonstration program which is aimed at testing the extent to which State and local governments and agencies can develop, coordinate, and manage long-term care services. The channeling demonstrations, a departmental initiative which cuts across all offices of the Department of Health and Human Services (HHS), are described more fully in chapter 4 of this report.

6. APPLICATION OF KNOWLEDGE AND PRACTICE

The fourth, and final, component of the AoA's discretionary grants strategy is devoted to improving capacity to serve older persons or the application of knowledge and practice. The capacity, and, conceivably, even the willingness of families, community agencies, State, and area agencies to care for the elderly is affected by the degree of skill and competence of the care givers. Since the AoA is charged with the responsibility to assist policymakers, administrators, and service providers and to provide improved methods for developing and managing services, the agency has committed education, training, and research funds to the development of knowledge through research, aggregating and organizing information for systematic distribution and to preparing users to incorporate knowledge in policy articulation, program implementation, and practice.

One method that the AoA has selected to use in improving capacity to serve older persons is through preservice career development and preparation. Title IV–A training funds are used to support the training of persons who are employed or preparing for employment in the field of aging. The AoA has also indicated a commitment to strengthening the capacity of institutions of higher education to prepare persons for careers in aging and to retrain persons already working with older people. The priorities established in career preparation for 1980 are:

—Policy formulation, planning, and management.
—Case management or services management.
—Administration of services, including health, mental health, legal services, employment guidance and counseling, home care, day care, protective services, and transportation; and
—Administration of services to special populations such as minority groups, the rural elderly, the inner-cities elderly.

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7. MINORITY RESEARCH PROGRAM

The minority research associate program was initiated by the AoA in response to the 1978 amendments to the OAA. This program provides support for minority institutions under the career preparation programs. It is also expected to increase the participation of minority scholars in the field of aging research. Five projects have been funded with institutions or organizations in an effort to recruit qualified minority social scientists and to stimulate research activity focused on expansion of knowledge concerning the needs of racial and ethnic minority elderly. These projects include Asian Pacific Americans, blacks, Hispanics, and Native Americans and aim to improve services to meet these groups' needs.

In 1980, the AoA funded 22 continuing education and technical assistance grants and contracts. These projects focus on the entire national network services system and range from the development of model information systems for State and area agencies to the development of curricula on serving minorities. Under this rubric, projects have also been funded in the areas of long-term care, in-home services, senior centers, health promotion, and counseling.

Regional education and training programs (RETP's) were developed in each of the 10 Federal regions during 1980. The goal of this program is to foster, on a regional basis, a coordinated approach to education and training by promoting greater understanding and coordination among higher education institutions, State and area agencies on aging and local service providers. It is AoA's hope that such an approach, over a multiyear developmental period, will result in a more efficient use of the limited education and training funds available both from the OAA and from other sources. Under this program, the RETP's are charged to:

—Convene regular regional conferences to bring together representatives from higher education institutions, State and area agencies and service providers to discuss common problems and opportunities.

—Convene regional research utilization and dissemination conferences around content areas of interest to both academic and practitioners.

—Prepare inventories of all education and training resources available in the region and develop procedures for better utilization of these resources; and

—Act as a regional clearinghouse for gathering and disseminating educational, training, and technical assistance materials.

G. Disaster Relief—A Different Use of Discretionary Funds

The AoA also has authority to use discretionary funds for disaster relief. The Disaster Relief Act of 1974 provides for assistance by the

Federal Government to State and local governments in carrying out their responsibilities to alleviate suffering and damage resulting from major disasters or emergencies such as hurricanes, tornados, snowstorms, fires, etc. The OAA authorizes the AoA to reimburse a State for funds that it makes available to area agencies for delivery of social services during a major disaster. These funds are to be taken from the AoA's title IV discretionary funds. During fiscal year 1980, food, clothing, and shelter were provided to disaster victims in Ohio, Washington, Nebraska, Wisconsin, and Alabama.

H. Title V—Senior Community Service Employment Program

Legal authority and funding for the senior community service employment program (SCSEP) is under title V of the OAA. The program is implemented by the Department of Labor through the Office of National Programs, Older Worker Work Group, Employment and Training Administration. Funds for the SCSEP are awarded to eight national organizations and all State governments which in turn promote the creation of part-time jobs in community service activities for low-income persons over the age of 55.

The 1978 amendments (Public Law 95–478) to the OAA made a number of significant changes in the SCSEP and redesignated title IX of the act as title V. Major changes in the law and the proposed regulations include:

—A requirement for more cooperation among all project sponsors.
—An increase in the private or other unsubsidized placement goal to at least 15 percent.
—A reordering of the priorities for enrollment.
—A State residency requirement.
—An increase in income eligibility level to 125 percent of the poverty guideline.
—A provision to allow project sponsors to establish a time limitation on enrollment with written authorization from the Assistant Secretary.
—A stricter limitation on payment of Federal funds into retirement fund for enrollees; and
—An increase to 75 percent of that share of Federal funds that must be used for wages and fringe benefits for enrollees.

Draft rules to implement this title were published on March 25, 1980 (vol. 45, Federal Register, p. 19530), with public comments on the proposed rulemaking due on or before May 27, 1980. This notice of proposed rulemaking (NPRM) was to revise the rules for the SCSEP which has been in effect since the beginning of the program in 1976. Since that time, funding and participants had grown almost fourfold. The number of grantees in 1980 was nearly 12 times the number in 1976 and grants were available both to units of government and private nonprofit organizations.

The proposed rules were based both on the new requirements from the 1978 amendments and the Department of Labor's (DOL) experience with this program. That experience, as well as the proposed rules, were thoroughly examined by the older worker work group staff of the Employment and Training Administration and a specially formed project sponsors' work group. As a result of this early input, it was DOL's hope that the proposed rules would be acceptable to sponsoring organizations, State governments, and other Federal agencies and older workers; could be immediately used by the implementing agencies; and would require little or no revision before final publication.

Although the mandatory comment period on the NPRM closed in May 1980, as of January 1981, final rules had not been published by DOL. Repeated inquiries from DOL have elicited the same response: "Although the regulations are significant, they are not 'major' and staff resources to finalize the regulations have not been available."

Grants totaling $258.8 million to support 52,250 part-time community service jobs for poor persons age 55 and over were awarded to eight national organizations and all State governments by Secretary of Labor Ray Marshall in early July 1980.

At the time of release, Secretary Marshall indicated that the funds would cover the 12-month period, July 1980 through June 1981, and that the program would operate in every State and territory.

Eight national organizations (headquarters in parentheses) received grants totaling $198.5 million:

—Green Thumb, Inc. (Washington, D.C.), an arm of the National Farmers' Union, $76.7 million.
—National Council on the Aging (Washington, D.C.), $22 million.
—National Council of Senior Citizens (Washington, D.C.), $43.2 million.
—National Retired Teachers Association/American Association of Retired Persons (Washington, D.C.), $32.2 million.
—U.S. Department of Agriculture's Forest Service (Washington, D.C.), $15.4 million.
—National Center on Black Aged (Washington, D.C), $2.4 million.
—National Association Pro Spanish-Speaking Elderly (Los Angeles, Calif.), $2.4 million.
—National Urban League (New York City, N.Y.), $4.2 million.

In addition to the grants to the eight national organizations, $59.8 million was provided to the State and territorial governments to create SCSEP jobs. Seven States chose to assign responsibility for operating their State SCSEP grants to one or more of the eight national organizations. Those States include Alabama, Florida, Kansas, New Hampshire, New Jersey, North Dakota, South Dakota, and Puerto Rico.

SCSEP workers fill part-time jobs at senior citizen centers, schools, hospitals, programs for the handicapped, fire prevention programs,

beautification, conservation and restoration projects. The participants must be paid no less than the Federal or State minimum wage or the local prevailing rate of pay for similar employment, whichever is higher. They receive annual physical examinations, personal and job-related counseling, job training if necessary, and in some cases, placement into regular unsubsidized jobs. Participants may work up to 1,300 hours per year and average 20–25 hours per week.

According to DOL, of all persons working in the program during the 1979–80 program year, 80 percent were over the age of 60, and 65 percent were women. More than 30 percent of the participants are minority group members and about 60 percent have less than a high school education. Approximately 50 percent of the workers are in jobs that provide services to the elderly (nutrition programs, outreach and referral, health and home care, transportation, etc.) ; 48 percent of the participants were in jobs created to provide services to the community at large.

The SCSEP has both an urban and rural focus and three of the eight national sponsors—Green Thumb, the Forest Service, and the National Center on Black Aged—operate primarily in rural areas.

The following tables give a breakdown of dollar allocations by State for each national sponsor and each State, as well as authorized participants levels:

SCSEP FOR 1980–81 PROGRAM YEAR—STATE ALLOCATIONS

Legend: A—Green Thumb, B—NCOA, C—NCSC, D—NRTA/AARP, E—Forest Service, F—NCBA, G—Spanish, H—Urban League

State	A	B	C	D	E	F	G	H	Governor's share
Alabama	$524,074	$340,335	$1,982,060	0	$258,989	$467,042	0	0	$1,077,500
Alaska	0	0	0	0	0	0	0	0	1,072,000
Arizona	85,540	1,474,051	0	0	395,311	0	0	0	604,098
Arkansas	2,996,980	0	0	$788,503	375,190	0	0	0	725,327
California	2,205,743	3,549,902	4,345,707	3,244,043	1,946,780	0	$587,567	0	4,421,258
Colorado	475,828	0	674,666	304,278	391,926	0	0	0	517,302
Connecticut	140,794	0	1,926,172	0	9,196	0	0	$349,320	673,518
Delaware	0	0	0	0	0	0	0	0	1,072,000
District of Columbia	682,825	0	495,461	29,888	0	0	0	0	278,826
Florida	3,021,706	350,561	1,420,633	4,544,821	449,628	286,752	291,177	0	2,987,722
Georgia	1,109,636	448,433	0	1,990,793	400,158	0	0	235,554	1,218,426
Guam	0	0	0	0	0	0	0	0	536,000
Hawaii	0	0	0	0	0	0	0	0	1,072,000
Idaho	183,939	0	0	219,559	500,087	0	0	0	278,475
Illinois	3,842,828	0	2,193,076	1,103,313	195,379	0	267,938	297,709	2,351,757
Indiana	3,226,539	0	1,580,496	332,514	78,149	0	0	299,953	1,256,349
Iowa	1,141,894	0	558,779	856,263	0	0	0	0	773,064
Kansas	1,722,569	0	0	0	0	0	335,638	0	599,793
Kentucky	1,743,978	809,975	0	690,657	331,011	354,716	0	0	973,663
Louisiana	1,021,371	413,301	571,210	587,301	336,869	0	299,971	0	958,977
Maine	167,536	920,777	0	172,481	41,407	0	0	0	338,799
Maryland	309,443	0	2,356,429	0	0	0	0	0	833,128
Massachusetts	854,668	0	3,376,265	383,923	0	0	0	300,012	1,461,132
Michigan	3,018,362	0	2,117,511	848,409	431,028	0	0	0	1,816,690
Minnesota	3,529,637	0	994,884	0	562,436	0	0	458,831	953,212
Mississippi	423,888	0	915,706	0	643,687	437,029	0	0	709,690

Missouri	3,204,548	268,422	385,020	810,266	511,947	0	0	0	1,359,797
Montana	900,143	0	0	269,015	182,792	0	0	0	279,050
Nebraska	1,214,771	0	0	389,558	25,286	0	0	0	431,385
Nevada	188,538	0	0	544,903	170,144	0	0	0	278,415
New Hampshire	325,372	0	0	339,199	179,374	0	0	0	279,055
New Jersey	3,461,063	1,278,079	1,275,322	0	0	0	0	349,266	1,640,270
New Mexico	0	0	0	415,606	507,149	0	0	0	284,245
New York	5,059,494	3,669,381	3,344,462	2,223,534	0	0	0	423,235	4,355,894
North Carolina	786,547	434,460	1,586,329	0	1,574,602	423,234	0	0	1,448,828
North Dakota	1,099,006	0	0	168,777	14,942	0	0	0	278,275
Ohio	2,529,781	1,021,960	2,179,252	2,375,227	86,193	0	0	497,157	2,692,430
Oklahoma	2,420,069	0	0	404,948	99,995	0	299,985	0	834,003
Oregon	1,562,352	245,940	0	517,481	743,727	0	0	0	617,500
Pennsylvania	4,820,245	1,963,029	2,565,418	1,128,924	301,113	0	0	365,700	3,302,980
Puerto Rico	996,812	0	0	1,006,730	102,287	0	0	0	647,171
Rhode Island	0	0	370,149	708,096	0	0	0	0	278,755
South Carolina	797,438	248,073	569,176	501,108	275,913	0	0	0	728,292
South Dakota	1,319,667	0	0	187,252	50,576	0	0	0	278,505
Tennessee	1,329,184	479,923	1,187,998	0	474,606	409,492	0	0	1,233,797
Texas	4,704,563	1,490,776	1,292,803	2,161,783	126,435	0	299,995	0	2,834,645
Utah	735,191	0	0	0	577,354	0	0	0	278,455
Vermont	100,489	915,288	0	0	111,459	0	0	0	278,764
Virgin Islands	0	0	0	0	0	0	0	0	536,000
Virginia	2,271,563	499,644	0	859,450	379,138	0	0	299,990	1,138,215
Washington	539,401	0	552,763	941,024	608,645	0	0	0	802,167
West Virginia	194,591	1,139,872	700,930	0	315,993	0	0	0	595,614
Wisconsin	3,227,535	0	1,698,122	0	427,378	0	0	300,021	1,187,944
Wyoming	486,384	0	0	172,331	244,870	0	0	0	278,415
American Samoa	0	0	0	0	0	0	0	0	539,000
Pacific Islands	0	0	0	0	0	0	0	0	536,000
National total	76,704,525	21,962,773	43,216,799	32,251,958	15,439,149	2,378,265	2,382,271	4,176,748	59,811,512

SCSEP FOR 1980–81 PROGRAM YEAR

[Total State-by-State allocations and authorized participant levels]

State	Allocation	Number of participants	State	Allocation	Number of participants
Alabama	$4, 650, 000	941	New Hampshire	1, 123, 000	227
Alaska	1, 072, 000	217	New Jersey	8, 004, 000	1, 619
Arizona	2, 559, 000	518	New Mexico	1, 207, 000	244
Arkansas	4, 386, 000	988	New York	19, 076, 000	3, 858
California	20, 301, 000	4, 106	North Carolina	6, 254, 000	1, 265
Colorado	2, 394, 000	484	North Dakota	1, 561, 000	316
Connecticut	3, 099, 000	627	Ohio	11, 382, 000	2, 302
Delaware	1, 072, 000	217	Oklahoma	4, 059, 000	821
District of Columbia	1, 487, 000	301	Oregon	3, 687, 000	746
Florida	13, 353, 000	2, 701	Pennsylvania	14, 448, 000	2, 922
Georgia	5, 403, 000	1, 093	Puerto Rico	2, 753, 000	557
Guam	536, 000	108	Rhode Island	1, 357, 000	274
Hawaii	1, 072, 000	217	South Carolina	3, 120, 000	631
Idaho	1, 182, 000	239	South Dakota	1, 836, 000	371
Illinois	10, 252, 000	2, 074	Tennessee	5, 115, 000	1, 035
Indiana	6, 774, 000	1, 370	Texas	12, 911, 000	2, 621
Iowa	3, 330, 000	674	Utah	1, 591, 000	321
Kansas	2, 6 8 000	538	Vermont	1, 406, 000	284
Kentucky	4, 904, 000	992	Virginia	5, 448, 000	1, 102
Louisiana	4, 189, 000	847	Virgin Islands	536, 000	108
Maine	1, 641, 000	332	Washington	3, 444, 000	697
Maryland	3, 499, 000	708	West Virginia	2, 947, 000	596
Massachusetts	6, 376, 000	1, 290	Wisconsin	6, 841, 000	1, 383
Michigan	8, 232, 000	1, 665	Wyoming	1, 182, 000	239
Minnesota	6, 499, 000	1, 315	American Samoa	536, 000	108
Mississippi	3, 130, 000	633	Trust Territory of the Pacific Islands	536, 000	108
Missouri	6, 540, 000	1, 323			
Montana	1, 631, 000	330			
Nebraska	2, 061, 000	417	Total	258, 324, 000	52, 250
Nevada	1, 182, 000	239			

The second continuing resolution, signed into law by President Carter on December 16, 1980 (Public Law 96–536), included an increase of $10 million over the administration's fiscal year 1981 budget request, and $10.2 million over the 1980 funding level for the SCSEP. This increase was provided by the House of Representatives during their deliberations on the Department of Labor and Health and Human Services 1981 appropriations bill (H. Rept. 96–1244).

Since the program is primarily forward-funded, with a program year from July 1 to June 30, the funding increase is expected to expand the program from the current level of 52,250 jobs to 54,200. The fiscal year 1981 appropriations also included an increase of $8.7 million to provide for higher minimum wage costs but this is offset by a reduction of $8.5 million to reflect the fact that 4,750 of these jobs were funded for 17 months in the 1980 appropriations act.

The House committee included language in the bill earmarking 80 percent of the appropriations for national contracts. This language created a discrepancy between the law and the appropriations measure. The 1978 amendments to the OAA directed more job slots to State governments by changing the allocation formula and stipulating that any additional funding in succeeding fiscal years would be allotted at 55 percent for the States and 45 percent for the national organizations.

When voting on the continuing resolutions, the Senate Appropriations Committee did not propose an increase for title V but supported the $10 million added by the House of Representatives.

As of December 31, 1980, confusion surrounding the allocation formula still existed. The matter was referred to DOL's Office of the Solicitor; resolution on the allocation formula is expected early in 1981.

I. Title VI—Grants to Indian Tribes for Social and Nutritional Services

The 1978 amendments to the Older Americans Act (Public Law 95–478) created title VI, a new direct grant program to Indian tribal organizations for older Indians. The purpose of this title was to promote the delivery of social and nutritional services comparable to those services provided through the State and community programs on aging under title III. Under this new title, tribal organizations would be eligible to apply for direct funding to pay the costs of providing social and nutritional services to Indians aged 60 and older. These funds could also be used for the acquisition, alteration, or renovation of multipurpose senior centers.

The law required the AoA to promulgate regulations to implement this title within 90 days of enactment. However, the AoA did not publish the proposed regulations until December 5, 1979, 13 months after enactment of the law. An additional 7 months passed before final regulations were forthcoming.

During the comment period, the AoA conducted nine public hearings at sites located in seven Federal regions. Approximately 200 representatives of Indian tribes, State and area agencies on aging, and national organizations testified or submitted written comments on the proposed regulations. Throughout the comment period, AoA staff consulted with national organizations and Federal agencies including the National Indian Council on Aging (NICOA), the Administration for Native Americans (ANA), the Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA). The final regulations, published on July 18, 1980 (vol. 45, Federal Register, p. 48380), reflected the comments of the various agencies consulted.

Concurrent with the development of the title VI regulations, the AoA was developing regulations for title III, grants for State and community programs on aging. Final regulations for the title III programs were published on March 31, 1980 (vol. 45. Federal Register, p. 21126). Since many of the provisions in title III were incorporated into the final regulations for title VI, the AoA insisted that the mandate to publish title VI regulations 90 days after enactment of the law was impossible and would have resulted in inconsistencies between the two programs. The AoA consequently published the title VI regulations 4 months after issuance of final rules for title III, 18 months later than required by congressional mandate.

The OAA establishes the general relationship between titles III and VI in the statement of purpose for each title. In the statement of purpose for title III, State and area agencies are charged with the responsibility of planning and providing social and nutrition services, including multipurpose senior centers, to help "secure and maintain maximum independence and dignity in a home environment for older individuals." Section 601 of title VI states:

> It is the purpose of the title to promote for Indians the delivery of social services, including nutrition services, that are comparable to services provided under title III.

The AoA analyzed the relationship between the provisions of title III and title VI and determined that the title III objective to assure maximum independence and well-being for all older persons is equally

valid for title VI. The unique characteristic of title VI is that it is designed to accomplish these goals for older Indians through direct Federal grants to eligible Indian tribal organizations, rather than through State and area agencies.

While the two titles parallel one another, the AoA was cautious not to extend the parallelism too far. Following the guidance provided by the public hearings, and written comments on the regulations, the AoA recognized the unique cultural differences of the Indian population and the frequent necessity to propose choices for the special cultural needs of older Indians.

Section 604 of the act establishes specific relationships between the service requirements for titles III and VI which includes:

—Full compliance by title VI grantees with certain title III requirements concerning the acquisition, alteration, or renovation of multipurpose senior centers; and

—The provision of nutrition, legal, and ombudsman services under title VI to be delivered or made available "substantially in compliance" with the provisions of title III.

A question arose during the development of the title VI regulations as to the meaning of "substantially in compliance." The AoA chose to interpret this phrase to mean that tribal organizations under title VI need meet only certain essential requirements for service delivery. In those cases in which title III requirements for nutrition, legal, and ombudsman were omitted, the AoA determined that the special nature of services for Indians under title VI made the title III requirements inappropriate or overly burdensome.

The title VI regulations also omitted several of the title III service delivery requirements including the preference for those with greatest economic or social needs and the development of a comprehensive and coordinated service delivery system. The AoA, following congressional intent, drafted regulations which provided considerable flexibility to tribal organizations in administering this new title. These regulations specify only those services which must comply with certain title III service requirements and allow tribes the flexibility to provide other services in the manner best suited to the cultural setting.

Flexibility was also provided in the title VI regulations in three basic service categories: nutrition, legal, and ombudsman services. The major changes from title III consist of:

—The addition of a nutrition requirement that special means be provided which meet the particular health, religious, cultural, and dietary needs of individual older Indians; and

—The inclusion of legal and ombudsman services for the selection of providers with expertise in areas of law affecting older persons and the demonstrated capacity to effectively deliver legal services to older persons.

The final title VI regulations clarified the definition of tribal organization and further explained tribal eligibility and tribal selection by older Indians. The definition of "tribal organization" used in the regulations was taken from the Indian Self-Determination and Education Assistance Act. This definition permits three types of tribal organizations to apply:

—The recognized governing body of a tribe.
—Any legally established organization of Indians which is controlled, sanctioned, or chartered by a governing body; or
—One individual democratically elected by the adult members of the Indian community served by the organization.

Both the act and regulations further provided that an organization may perform services benefiting more than one tribe, with the approval of each tribe to be served.

The law specifies that tribal organization may not receive funds from both titles III and VI for the duration of a grant. Therefore, each Indian tribe was encouraged to decide which type of organization could best serve the older members of the tribe. Since title III social services are not provided to tribal organizations, but rather to individual older persons, the regulations clearly stipulated that a tribal organization providing services under both titles III and VI must take whatever steps necessary to insure that the same individuals do not receive services under both titles. Additionally, if tribal organizations do receive funds under both titles, the funds must be administered in accordance with the applicable provisions of the titles under which those funds are received and costs must be allocated for any shared equipment and facilities.

In fiscal year 1980, an initial allocation of $6 million was provided for title VI. Grantees were required to provide nutrition and legal services, and to insure that information and referral services were readily available. If there is a long-term care facility under the jurisdiction of the tribal organization, then an ombudsman program must be established.

During the early months of 1980, and prior to allocation of the title VI funds, the AoA attempted to contact all federally recognized tribes. Approximately 500 tribes were invited to apply for this direct funding. A total of 86 formal applications were submitted to the AoA. These applications were reviewed by a panel of representatives from agencies with special Indian programs and 85 grants were awarded to tribal organizations representing more than 20.000 older Indians. The awards were made not only for service to elderly Indians, but also to develop the capacity of the grantee organizations to provide service to older Native Americans.

J. Older Americans Act Funding

1. FISCAL YEAR 1980 APPROPRIATIONS

Fiscal year 1980 appropriations (Public Law 96–123) for OAA programs provided an increase of $150 million, a 16-percent increase over the 1979 funding level. Additional funding was necessary for States to comply with the expanded mandates of the 1978 amendments. These new mandates include direct grants for Indian tribes, a nutrition program providing federally funded home-delivered meals, and prohibiting the use of nutrition funds for supportive services effective in fiscal year 1981. Highlights of the fiscal year 1980 funding increases include: [1]

[1] Charts showing appropriations for fiscal years 1980–81 and fiscal years 1966–81 are on a later page.

—Title III–B, social services: A $50-million increase to maintain social services at the 1979 level, to provide transportation services, senior centers, and other supportive activities to the nutrition program, and to begin to compensate for the fiscal year 1981 prohibition on the use of nutrition funds for supportive activities.
—Title V, community service employment: A $57-million increase to expand job slots from 47,500 to 52,250 for the period from July 1, 1980, through June 30, 1981, and to synchronize funding with other OAA programs.
—Title VI: $6 million in initial funding for grants to Indian tribes to promote the delivery of social services to Indians.

Fiscal year 1980 funding levels

	Funding levels (in millions)
Title II:	
National Clearinghouse	$2.00
Federal Council on Aging	.45
Title III:	
State administration	22.50
Social services	246.97
Congregate meals	270.00
Home-delivered meals	50.00
Title IV:	
Training	17.00
Research	8.50
Multidisciplinary centers	3.80
Special projects (including long-term care and legal services)	20.50
Title V: Community service employment [1]	266.90
Title VI: Direct grants to Indian tribes	6.00
Total	914.62

[1] Title V is administered by the Department of Labor (DOL) with a program year from July 1979 through June 1980.

2. FISCAL YEAR 1981 APPROPRIATIONS

Fiscal year 1981 funding for OAA programs will be provided under the authority of continuing resolutions until June 5, 1981. The House of Representatives passed its fiscal year 1981 Labor, Health and Human Services appropriations measure (H.R. 7998) on August 27, 1980. The Senate Appropriations Committee did not report a fiscal year 1981 appropriations bill. Therefore, a continuing resolution to guarantee Federal funding for a number of Federal agencies and programs was required.

The first continuing resolution, signed into law on October 1, 1980, provided funding until December 15, 1980 (Public Law 96–369). Since the Senate still had a number of appropriations measures pending on December 15, a second continuing resolution was necessary before the 96th Congress adjourned. The second resolution, signed into law on December 16, 1980 (Public Law 96–536), provides funding through June 5, 1981.

The House Appropriations Committee reported H.R. 7998 on August 21 (H. Rept. 96–1244). The committee's version recommended the following program increases:

—Title III–B, social services and centers: A $10-million increase to defray costs of support services transferred from nutrition to social services.

—Title III–C, nutrition: A $30-million increase to cover the increased cost of meals served and to provide expansion in the number of meals served.

—Title V, senior community service employment: An increase of $10.2 million to expand the program from the current level of 52,250 jobs to 54,200 and to provide for higher minimum wage costs.

Since the Senate Appropriations Committee did not report its version of the fiscal year 1981 appropriations for Labor, Health and Human Services, committee members found it necessary to present an amendment to the House version during the conference on the continuing appropriations measure for fiscal year 1981. During conference deliberations, Senator Lawton Chiles introduced an amendment to provide funding for the following OAA programs:

—Title III–B, social services and centers: $280 million, an increase of $33 million over the House version to protect community services against inflation.

—Title IV, research, training and special projects: $38.1, a $7.4-million reduction over the House proposal to highlight the inadequate information provided to Congress regarding the use of the Commissioner's discretionary funds; and

—White House Conference on Aging: $3 million, the same as the House-passed version (inadvertently omitted from the House continuing appropriations measure H.J. Res. 610) for a total of $6 million for the Conference.

The conferees agreed to a $30-million increase for title III community services during its deliberations on the continuing resolution. This increase was dropped however, when the dispute over Federal pay caused the House to pass a "stripped-down" resolution with most Senate amendments deleted. The House version, which became law on December 16, 1980, retained the $45.5 funding level for title IV and provided continuing funding authority at the $3 million level for the White House Conference on Aging.

Further continuing resolution funding levels, fiscal year 1981

	Funding level (in millions)
Title II:	
National Clearinghouse	$2.000
Federal Council on Aging	.581
Title III:	
State agency administration	22.675
Social services and senior centers	257.000
Congregate meals	295.000
Home-delivered meals	55.000
Title IV:	
Training	14.000
Research	6.000
Gerontology centers	3.000
Special projects (including long-term care and legal services)	22.500
Title V: Senior community service employment [1]	277.100
Title VI: Direct grants to Indian tribes	6.000
Total	960.856

[1] Title V is administered by the Department of Labor (DOL) with a program year from July 1980 through June 1981.

OLDER AMERICANS ACT APPROPRIATIONS, FISCAL YEARS 1966–80

[In thousands of dollars]

	1966	1967	1968	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
Title II:[1]																
National Information and Resource Clearinghouse	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	None	None	None	None	2,000	2,000	2,000	2,000
Federal Council on the Aging	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	None	0.575	0.575	0.575	.450	.450	.450	.581
Title III:																
Area planning[3] and social services	5,000	6,000	10,550	16,000	9,000	9,000	30,000	68,000	68,000	82,000	93,000	122,000	193,000	196,970	246,970	257,000
State agency activities[3]	None	None	None	None	4,000	4,000	5,000	12,000	12,000	15,000	17,035	17,000	19,000	22,500	22,500	22,675
Multipurpose senior centers	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	None	None	None	[4] 20,000	[4] 40,000	(5)	(5)	(2)
Nutrition program	(2)	(2)	(2)	(2)	(2)	(2)	(2)	100,000	104,800	125,000	[6] 125,000	[6] 203,525	250,000	277,046	320,000	350,000
Title IV:																
Training	.500	1,403	2,245	2,845	2,610	1,000	8,000	8,000	10,000	8,000	10,000	14,200	17,000	17,000	17,000	14,000
Research	1,000	1,507	4,155	4,185	3,250	2,800	9,000	9,000	7,000	7,000	8,000	8,500	8,500	8,500	8,500	6,000
Model projects, special projects	(2)	(2)	(2)	(2)	None	None	9,700	16,000	16,000	8,000	13,800	12,000	15,000	15,000	25,000	22,500
Mortgage insurance and interest subsidies for senior centers	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	None	None	None	[4] None	None	None	None	None
Multidisciplinary centers of gerontology	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	None	None	1,000	3,800	3,800	3,800	3,800	3,000
Title V: Community service employment for older Americans[7]	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	10,000	42,000	55,900	90,600	200,900	200,900	266,900	277,100
Title VI: Grants for Indian tribes	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	(2)	None	6,000	6,000
Foster Grandparent program	(8)	(8)	(8)	8,968	9,250	10,000	25,000	25,000	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
Retired senior volunteer program	(2)	(2)	(2)	(2)	None	.500	15,000	15,000	(8)	(8)	(8)	(8)	(8)	(8)	(8)	(8)
Total	6,500	8,910	16,950	31,998	28,110	27,300	101,700	253,000	227,800	287,575	324,310	492,200	749,650	744,166	919,120	960,856

[1] The title numbers are based on the 1978 amendments.

[2] Not authorized.

[3] Between 1965 and 1970, title III funds were allocated to States for social services. There was no appropriation for State or area planning activities. Beginning in 1970 funds were appropriated for statewide planning. In 1973 funds were appropriated for area planning and social services.

[4] The appropriation covered grants, mortgage insurance and annual interest subsidies, but funds were allocated for grants only.

[5] Multipurpose senior centers are funded under the title III area planning and social services appropriation.

[6] Congressionally mandated operating levels made possible through forward funding were $150,000,000 for fiscal year 1975 and $187,500,000 for fiscal year 1976. Program operating level for fiscal year 1977 was $225,000,000.

[7] Funding is available on an annual basis beginning July 1 and ending the following June 30.

[8] The Foster Grandparent program was funded under a general poverty program through the Economic Opportunity Act from 1977 through 1968. This program was given a statutory basis under the Older Americans Act of 1969. In addition, the retired senior volunteer program was created under the 1969 amendments. Legislative authority under the Older Americans Act was repealed in 1973 and both these programs were reauthorized under the Domestic Volunteer Service Act of 1973 (Public Law 93–113).

K. Office of Human Development Services—1980 Reorganization

The Office of Human Development Services (OHDS) is the social services arm of the Department of Health and Human Services (HHS) which provides national program direction and services through its components: The Administration on Aging; Children, Youth, and Families; Native Americans; Developmentally Disabled; Public Services (title XX programs); the President's Committee on Mental Retardation; and the work incentive program. Created in 1977, the OHDS was designed to improve coordination and management of the various social service programs funded through the above-mentioned agencies.

On May 18, 1980, Secretary of HHS, Patricia Roberts Harris, pursuant to the authorities vested in that position, issued an executive order authorizing the reorganization of OHDS. The reorganization order, published on May 21 (45 FR 34069), made a number of organizational changes directly affecting the Administration on Aging (AoA).

According to Secretary Harris, the OHDS reorganization was prompted by two principal concerns: The organizational disruption which occurred when several OHDS components were transferred to the newly created Department of Education in May 1980; and the desire of management officials to strengthen the administration and coordination of social service programs by establishing a more efficient organizational structure.

1. Highlights of the OHDS Reorganization

One purpose of the May 1980, OHDS reorganization was to provide an organizational placement which would administer title XX as the special revenue-sharing program that it was intended to be, through a structure which permits title XX integration and coordination with other social services programs. The Department had determined that the parallel placement of title XX program unit with other administrations prevented this from occurring. The title XX program, located within the OHDS, represents over half of OHDS's total budget, an estimated $3 billion annual funding level.

Abolishment of the Administration for Public Services

To accomplish the objectives set forth in the OHDS reorganization, the Administration for Public Services (APS) was abolished and a substantial number of its title XX staff subsequently were transferred to various other OHDS program offices to facilitate services coordination, planning, and review. The remaining APS staff, along with the basic financial and training components of the title XX program, were transferred to a newly created staff office—the Office of Program Coordination and Review—which is located organizationally under the direct administrative and line authority of the Assistant Secretary.

The Administration on Aging was the beneficiary of approximately 40 out of 100 total title XX program positions. These positions were divided equally between the regional offices and headquarters. A number of these new positions were intended to strengthen AoA's opera-

tion of its long-term care, research, and program development units. The OHDS reports that this is the largest increase in personnel that AoA has received since the expansion of the Older Americans Act in 1972.

Concurrent with the transfer of APS positions to the OHDS program administrations, leadership responsibilities were delegated to the respective Commissioners for setting program quality standards, substantive technical assistance, and program compliance monitoring for all OHDS-funded categorical social services (including those services funded by title XX). By eliminating the Administration for Public Services, HHS officials contended that such programs as the Administration on Aging would have a more significant impact on the way title XX is administered, to the benefit of the older population.

Secretary Harris, testifying before the House Select Committee on Aging, July 23, 1980, defended the title XX integration objectives of the reorganization by stating:

> The Commissioner on Aging, for instance, will now provide leadership for all programs addressing the needs of the elderly funded through title XX. The Commissioner's influence over the quality, type, and delivery of services will be significantly increased. For example, AoA staff will now be involved in a joint review of title XX State plans with the Office of Program Coordination and Review staff to insure that the needs of the elderly in the States are considered in the development of the plan. In addition, AoA staff will be asked to provide expertise on elderly issues examined by the other program administrations. This structure should significantly strengthen our program operations.

Title XX State Plan Coordination and Joint Reviews

Pursuant to the mandates of the OHDS reorganization order, the Office of Program Coordination and Review was created at both the central office (Washington, D.C.) and regional office levels.

The Office of Program Coordination and Review (OPCR) in the OHDS central office maintains the residual title XX functions, including training and financial management of the program. Furthermore, this new staff office is responsible for promoting the coordination of social services throughout OHDS; managing special projects affecting OHDS target groups; and providing direction to the OHDS regional offices. The OHDS regional administrators report directly to the Director of OPCR in Washington, D.C.

The mission of the OPCR at the regional level is to function as the administrative vehicle directly responsible for the following: Insuring State compliance with title XX administrative requirements; reviewing the overall human services delivery systems in the States; and coordinating, with the regional program staff, reviews of State plans. This last functional mandate, the joint reviews of State plans, is intended to be the driving force within the OHDS regional offices in fostering a sharing of information about State services and to enforce the development of more consistent, comprehensive policies directed toward enhancing social programs for all OHDS target populations.

Consolidation of Financial Management Functions

Financial management responsibilities of all OHDS programs in the regions have been consolidated under the Office of Fiscal Operations (OFO). While the program administrations retain policy control and allocation authority, this office is responsible for fiscal monitoring of all OHDS grantees.

The benefits of a consolidated financial staff were described in written correspondence from Secretary Harris to Congressman Charles Grassley (May 13, 1980). Secretary Harris indicated that the OFO would "eliminate duplicative financial monitoring of those service providers which are grantees under more than one OHDS program."

Prior to the OHDS reorganization order, each regional program office maintained its own separate financial management staff and functional responsibility. Subsequent to the reorganization, all AoA regional financial management officers were transferred to, and their functions consolidated under, the new regional Office of Fiscal Operations. The Administration on Aging, therefore, forfeited direct administrative, financial authority over a total of 13 financial management positions throughout the regions.

Department officials anticipated that a financial management core staff would maintain the knowledge of all OHDS statutory and administrative financial requirements and, as a result, would serve as a single, comprehensive source of expertise concerning service requirements and technical assistance to State and local agencies.

2. AGING CONSTITUENCY REBUTTAL; CONGRESSIONAL CONCERN

In the weeks preceding its official enactment, consideration of the OHDS reorganization order evoked considerable concern among various Members of Congress and aging organizations. This concern was based on the belief that implementation of the OHDS reorganization, as proposed, would not necessarily serve in the best interests of the social service needs of the elderly nor significantly enhance the administration of the Older Americans Act programs.

Congressional opposition to the reorganization was initiated by members of the Senate Special Committee on Aging and House Select Committee on Aging. Specific issues of concern, as well as questions challenging the intent and legality of the reorganization included:

—Statutory authority of the Secretary to reorganize OHDS.
—Loss of fiscal responsibilities and corresponding financial management staff positions from AoA regional program offices.
—Failure to enhance the visibility of the Administration on Aging; and
—Organizational placement and distribution of 40 positions allocated to AoA.

The Department of Health and Human Services (HHS) was also cited for its failure to notify Congress and national aging organizations in advance. Early notification would have facilitated a more thorough review and analysis of, and involvement in the formulation and final decisionmaking regarding implementation of the OHDS reorganization.

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As a result, formal requests were submitted to Secretary Harris urging a 60-day postponement of the reorganization—a time period intended to permit full assessment of its impact on the Administration on Aging and other OHDS components. The requested delay in the OHDS reorganization was petitioned for by a significant number of congressional members and aging groups including: Senators John Heinz, Pete Domenici, William Cohen, Charles Percy, and Nancy Kassebaum from the Senate Special Committee on Aging; and the unified backing of 12 national aging memberships, provider, and professional organizations.

Chronology of Events

On April 24, 1980, DHHS officials formally notified Members of Congress and, in particular, the Senate and House Committees on Aging, of the Department's desire to implement the OHDS reorganization order. Meetings between congressional aging committee staff and the OHDS Deputy Assistant Secretary were held to inform and clarify both the organizational and programmatic changes proposed in the reorganization plan. Although they questioned in particular the Secretary's authority to reorganize OHDS, the committees also had other important concerns with regard to the growth of the OHDS as a staff office—a layer of the bureaucracy. Such concerns included the possibility of setting a precedent for absorbing OHDS program components into the central office operation; and that the authority and organizational stature of AoA would be diminished and AoA responsibilities would be delegated to offices beyond the control of the Commissioner. An example of this was the removal of certain fiscal responsibilities from AoA at the regional level. The Members of Congress and national aging organizations objected to the transfer of 13 AoA regional financial management staff to the newly created Office of Fiscal Operations because they felt that the views of State and local administrators involved in providing services under the Older Americans Act should have been solicited to determine the impact of the proposed action on services.

On May 2, 1980, Senator Pete V. Domenici wrote to Secretary Harris requesting a delay in the reorganization. On the same day, 12 national aging organizations made a similar plea. This quickly was followed on May 8, with a letter from several Senators reinforcing this request.

In a written response (May 13, 1980) to Congressman Charles Grassley, ranking minority member of the House Select Committee on Aging, Secretary Harris defended her authority to reorganize by stating:

> The authority (to reorganize) is contained in the Reorganization Plan No. 1 of 1953, which created the Department of Health, Education, and Welfare. Section 1 of the reorganization plan provides that the Department shall be administered under the supervision and direction of the Secretary. Section 6 provides that the Secretary may make such provisions as she deems appropriate authorizing the performance of the functions of the Secretary by any other officer, agency, or employee of the Department. Thus, the Secretary has the authority to organize the functions and offices of the Depart-

ment as she deems appropriate. Under the Department of Education Organizational Act (Public Law 96–88), the Department of Health and Human Services and its Secretary are successors to the Department of Health, Education, and Welfare and its Secretary, with secretarial authority under the reorganization plan unchanged.

Secretary Harris also assured Congressman Grassley, and members of the House Select Committee on Aging, that the Department "carefully reviewed the Older Americans Act and determined that the organizational changes to be made do not in any way conflict with the requirements of that act."

Despite this reassurance, the widespread opposition to the pending OHDS reorganization expressed by several national aging organizations prompted the Department to convene a meeting with the Secretary and representatives from the organizations to discuss the perceived adverse impact of the reorganization upon the program management responsibilities of the Administration on Aging. During their meeting on May 14, 1980, with the national aging representatives, Secretary Harris responded to the group by reaffirming her position as follows:

—That any delay in implementation of the plan would result in unnecessary hardships for many OHDS employees, since the reorganization was to become effective simultaneously with the transfer of the education components from HEW to the new Department of Education.

—That the reorganization would allow the consolidation of OHDS's limited financial management, thereby improving monitoring and assistance to grantees.

—That the reorganization would create the potential for efficient oversight of Federal outlays through economies of scale and new management systems.

—That the reorganization would create a vehicle for better coordination among the various program units; and

—That the reorganization would open the policy development process to program units.

The Secretary did agree to one concession requested by the group. This concession was to change the name of the Office of Program Integration and Review (OPIR) to the Office of Program Coordination and Review (OPCR) as a first step toward insuring that program units would retain autonomy and programmatic control. She concluded the meeting with an invitation to the group to return in 6 months for a review and evaluation of the reorganization.

Despite the numerous requests for reconsideration, on May 18, Secretary Harris issued the executive order authorizing the reorganization. On May 21, HHS published the announcement in the Federal Register.

On July 7, 1980, the Senate Special Committee on Aging, concerned in general with the legality of the OHDS organizational structure, requested the General Accounting Office (GAO) to conduct a preliminary survey of the structure, and to prepare a legal opinion with respect to the Administration on Aging and the Older Americans Act. Among the various issues to be addressed, the committee specifically instructed GAO's General Counsel to determine if the delegation of legislatively authorized functions of the Commis-

sioner on Aging to other OHDS offices not directly responsible to the Commissioner is legal and consistent with statutory intent.

Members of the Senate Special Committee on Aging had previously expressed concern about the organizational placement of AoA in the Department of Health and Human Services. During the Senate hearing on the confirmation of Cesar A. Perales, as Assistant Secretary of the Office of Human Development Services, Senator John Heinz posed the following questions: Whether AoA functions were being assigned to offices beyond the control of the Commissioner on Aging; whether the Commissioner was required to report directly to the Secretary; and whether staff positions initially designated for the AoA to administer the OAA were diverted to OHDS officers.

Assistant Secretary Perales responded on the day of the hearing, and also in a subsequently written response to Senator Heinz, that it was not the intent of the Department to circumvent the provision of section 201 of the Older Americans Act with respect to the authority of the Commissioner on Aging, and that all staff slots currently assigned to AoA were filled by persons reporting directly to the Commissioner.

On August 14, 1980, Milton Socolar, GAO General Counsel, responded to the committee's request for an opinion. The GAO opinion stated:

> A delegation of functions of the Commissioner to the OHDS officials not directly responsible to the Commissioner would violate the restriction in 42 U.S.C. 3011(a).

The opinion went on to explain that this delegation of functions did not have to be through a formal mechanism:

> Functions may be delegated in a formal or informal manner. Formal delegations may be made, for example, through a statement of mission, organization, function, and delegation of authority which is published in the Federal Register. On the other hand, informal delegations may be made by verbal orders, by office memoranda, or by custom and usage. In order to determine whether a function has been informally delegated, a determination must be made on a case-by-case basis.

The report also stated that while the location of AoA within OHDS was consistent with the requirement for the Commissioner to report directly to the Secretary, the Congress also intended the Commissioner to have "the requisite authority and responsibility to implement the important mission of the AoA." Furthermore, "Congress did not intend that the Commissioner should be required to deal with intermediate level officials in OHDS."

Although the GAO's legal interpretation was made subsequent to the May 18, 1980, OHDS reorganization order, it supported the concern of the national aging organizations regarding the authority of the Secretary to transfer AoA regional staff to an OHDS staff office which is outside the direct reporting purview of the AoA Commissioner. In this regard, the GAO made the following statement:

> Because AoA is a statutory agency and the Commissioner is by law the agency head, AoA regional staff are directly responsible to the Commissioner. The work of the AoA re-

gional staff is assigned and supervised by officials subordinate to the Commissioner. On the other hand, the OHDS Regional Administrator is responsible for coordinating OHDS programs for a specific area. Therefore, AoA regional staff may be required to coordinate their activities with the OHDS Regional Administrator.

A similar analysis was provided by the American Law Division of the Congressional Research Service to the House Select Committee on Aging. The CRS took the position that the law and congressional intent clearly prohibited the delegation of any functions, including policymaking and routine administrative services, to any officer not directly responsible to the Commissioner.

While the legal opinion supported the Secretary's authority to reorganize, concerns relative to the delegation of authority and the organizational placement of the AoA remained. These issues will, no doubt, receive careful scrutiny during the 1981 reauthorization of the OAA.

II. ACTION'S OLDER AMERICANS VOLUNTEER PROGRAMS

The three established older Americans volunteer programs—the senior companion program (SCP), the retired senior volunteer program (RSVP), and the foster grandparent program (FGP), saw modest growth in the 1980–81 period.

Two relatively new ACTION programs, relevant to older Americans, which saw more substantial expansion are the fixed income consumer counseling (FICC) and helping hand (HH).

The ACTION agency's older Americans volunteer programs (OAVP) are authorized under title II of the Domestic Volunteer Service Act of 1973 (Public Law 93–113). The most recent amendments to that act, included in the Comprehensive Older Americans Act Amendments of 1978 (Public Law 95–478), reauthorized the programs through fiscal year 1981. These programs serve the dual purpose of combining the talents and experience of older persons with unmet community and individual needs. Special emphasis is placed on serving the ill, the infirm, the isolated elderly, and youth who are emotionally, mentally, or physically disabled.

Categorical project grants are awarded by ACTION to private nonprofit organizations, and public agencies which recruit, place, and support volunteers. The volunteer services are, in turn, provided through public and private nonprofit agencies and proprietary health care facilities. The OAVP projects are locally sponsored and locally administered with basic program decisions made at the community or neighborhood level. Within the context of the legislation, volunteer activities derive from agreements among the volunteer project staff, and the community as represented by volunteer stations, advisory councils, and the volunteers themselves.

A. Retired Senior Volunteer Program

The retired senior volunteer program (RSVP) was established in 1971 to provide persons age 60 and over with opportunities for volunteer service in their own communities. The RSVP volunteers serve

more than 4 hours per week on the average, counseling other citizens in health and nutrition, consumer concerns, crime and victimization, banking and finance, rebate programs, legal problems, energy conservation, and fixed income expenditure. These older volunteers receive no stipend or wage but may be reimbursed for transportation up to $1.85 per day.

The fiscal year 1980 appropriation for RSVP was $26 million to allow expanded volunteer opportunities for approximately 17,000 older persons in 170 existing projects and to fund 22 new projects, enabling another 7,700 older persons to serve communities.

The RSVP program received a small increase in fiscal year 1981 funding—$1.717 million. The total appropriation of $27,717.000 will provide resources for 272,600 volunteers in 719 programs—707 continuing and 12 new.

B. Foster Grandparents

The foster grandparents program (FGP) used the "grandparent" concept, a social role which can be filled only by an older person. Foster grandparents are low-income people, age 60 and older, who provide supportive person-to-person services to children with exceptional or special needs. Foster grandparents serve 20 hours per week working with children—both in and out of institutions—who have mental, physical, or emotional handicaps. They seek to prevent or delay the institutionalization of children and to deinstitutionalize children who can live in the community when a limited number of services are provided. These grandparents receive a stipend of $2 per hour for their volunteer activities.

The fiscal year 1980 appropriation of $46.9 million allowed 17,000 grandparents to assist over 42,000 children. The fiscal year 1981 appropriation of $48,400,000 will provide resources for 17,877 volunteers in 219 programs—208 continuing and 11 new. These volunteers will assist approximately 54,000 children in all States, the District of Columbia, Puerto Rico, and the Virgin Islands.

C. Senior Companions

The senior companion program (SCP) provides the opportunity for low-income people age 60 and older to provide personal assistance and companionship primarily to other older adults. Senior companions serve 20 hours per week seeking to prevent or delay the institutionalization of the chronically homebound elderly, shorten the stay of those elderly temporarily institutionalized, and deinstitutionalize persons who are able to live at home when some services are provided. The volunteer companions also receive a stipend of $2 per hour for their services.

During fiscal year 1980, 80 percent of the senior companions were over 65 years of age, 46 percent were over 70, 74 percent of the volunteers were widowed or single, and 63 percent lived alone. Of the senior companions, 40 percent were nonwhite. Of those served by the senior companions, 81 percent were age 65 or older, and 50 percent were 75 years old or older. Approximately 60 percent of the clients live alone and 81 percent lived in their own homes.

The fiscal year 1980 appropriation of $10.200,000 provided stipends for 3,820 volunteers in 61 programs—54 continuing and 7 new pro-

grams. The fiscal year 1981 appropriation of $12,783,000, an increase of $2,583,000, will provide resources for 4,360 volunteers in 75 programs (62 continuing and 13 new programs).

D. New ACTION Programs

Reauthorization of the Domestic Volunteer Service Act at the end of the first session of the 96th Congress (Public Law 96–143) added two new programs to ACTION designed to benefit the elderly: fixed income consumer counseling and helping hand.

The primary objective of the fixed income consumer counseling (FICC) program is to provide volunteer assistance which will help individuals and families with limited incomes to expand and/or maximize the use of available resources by gaining access to entitlements, organizing citizen responses to common problems, and facilitating coordination of available consumer assistance resources. Although the program is responsive to persons of every age and employment status whose income is near or below the poverty guideline, the majority of persons helped by this program are retired low-income elderly.

Project grants for this new program average $50,000 and are available to communities with a population of 50,000 and which have high concentrations of people on fixed incomes. An average project utilizes 400 volunteers who serve a total of 80,000 hours working directly with 5,000 to 10,000 persons on fixed incomes. Multilingual services are provided through seminars, individual counseling, small group workshops, and literature. The activities take place on an outreach basis in nursing homes, adult care centers, schools, and community centers. The fiscal 1981 appropriation of $381,000 provides resources for 12 project grants. A pending supplemental 1981 appropriation requests an additional $2,589,000 to support an additional 48 project grants.

The helping hand program is part of a long-term demonstration to test the reduction in institutionalization of citizens by providing individual supportive services using volunteers in cooperation with professionals. The program will respond to the functional and psychological needs of deinstitutionalized people including the emotionally, mentally, and physically disabled. Twelve helping hand grants, averaging $50,000 each, will enable State and local institutions to train and support approximately 4,000 part-time volunteers.

E. Future of OAVP

The OAVP's authorizing legislation will expire September 30, 1981. The 97th Congress will be responsible for considering legislation necessary to extend and amend these programs.

III. TITLE XX—SOCIAL SERVICES

Following 6 years of a congressionally imposed ceiling of $2.5 billion for social services under the Social Security Act, Congress passed a 1-year-only increase in the title XX ceiling in 1978 and allowed $2.9 billion for services in fiscal year 1979. The Social Welfare Reform Amendments of 1979, which became law June 17, 1980 (Public Law 96–272), authorized a $200-million spending cut in the program by reducing the ceiling to $2.7 billion for fiscal year 1980.

Although there were cuts in social service spending in 1980, H.R. 3434 did prevent immediate cuts in State programs. Without the authority provided in Public Law 96–272, the title XX limit for 1980 would have reverted to its permanent level of $2.5 billion. That spending level would have required sharp reductions in State social service programs for the remainder of 1980.[2]

The House passed H.R. 3434 on August 2, 1979, and the Senate passed its version on October 29, 1980. Although the bill was approved in a Senate-House conference in April, it could not be considered for final action until after approval of the third budget resolution for fiscal year 1980. That resolution was cleared on June 12, allowing the conference report on H.R. 3434 to be approved in both the House and Senate by voice vote.

ALLOTMENT LIMITATION FISCAL YEAR 1980—FEDERAL ALLOTMENT

State	Social services	Child day care	Total
Alabama	$42, 642, 000	$3, 411, 360	$46, 053, 360
Alaska	4, 703, 000	376, 240	5, 079, 240
Arizona	26, 533, 000	2, 122, 640	28, 655, 640
Arkansas	24, 776, 000	1, 982, 080	26, 758, 080
California	253, 037, 000	20, 242, 960	273, 279, 960
Colorado	30, 266, 000	2, 421, 280	32, 687, 280
Connecticut	35, 917, 000	2, 873, 360	38, 790, 360
Delaware	6, 725, 000	538, 000	7, 263, 000
District of Columbia	7, 974, 000	637, 920	8, 611, 920
Florida	97, 674, 000	7, 813, 920	105, 487, 920
Georgia	58, 336, 000	4, 666, 880	63, 002, 880
Hawaii	10, 343, 000	827, 440	11, 170, 440
Idaho	9, 903, 000	792, 240	10, 695, 240
Illinois	129, 951, 000	10, 396, 080	140, 347, 080
Indiana	61, 595, 000	4, 927, 600	66, 522, 600
Iowa	33, 270, 000	2, 661, 600	35, 931, 600
Kansas	26, 880, 000	2, 150, 400	29, 030, 400
Kentucky	39, 962, 000	3, 196, 960	43, 158, 960
Louisiana	45, 312, 000	3, 624, 960	48, 936, 960
Maine	12, 538, 000	1, 003, 040	13, 541, 040
Maryland	47, 831, 000	3, 826, 480	51, 657, 480
Massachusetts	66, 818, 000	5, 345, 440	72, 163, 440
Michigan	105, 497, 000	8, 439, 760	113, 936, 760
Minnesota	45, 936, 000	3, 674, 880	49, 610, 880
Mississippi	27, 608, 000	2, 208, 640	29, 816, 640
Missouri	55, 482, 000	4, 438, 560	59, 920, 560
Montana	8, 794, 000	703, 520	9, 497, 520
Nebraska	18, 039, 000	1, 443, 120	19, 482, 120
Nevada	7, 315, 000	585, 200	7, 900, 200
New Hampshire	9, 811, 000	784, 880	10, 595, 880
New Jersey	84, 696, 000	6, 775, 680	91, 471, 680
New Mexico	13, 752, 000	1, 100, 160	14, 852, 160
New York	207, 135, 000	16, 570, 800	223, 705, 800
North Carolina	63, 848, 000	5, 107, 840	68, 955, 840
North Dakota	7, 546, 000	603, 680	8, 149, 680
Ohio	123, 654, 000	9, 893, 120	133, 557, 120
Oklahoma	32, 485, 000	2, 598, 800	35, 083, 800
Oregon	27, 458, 000	2, 196, 640	29, 654, 640
Pennsylvania	136, 191, 000	10, 895, 280	147, 086, 280
Rhode Island	10, 805, 000	864, 400	11, 669, 400
South Carolina	33, 236, 000	2, 658, 880	35, 894, 880
South Dakota	7, 962, 000	636, 960	8, 598, 960
Tennessee	49, 680, 000	3, 974, 400	53, 654, 400
Texas	148, 267, 000	11, 861, 360	160, 128, 360
Utah	14, 653, 000	1, 172, 240	15, 825, 240
Vermont	5, 581, 000	446, 480	6, 027, 480
Virginia	59, 341, 000	4, 747, 280	64, 088, 280
Washington	42, 273, 000	3, 381, 840	45, 654, 840
West Virginia	21, 483, 000	1, 718, 640	23, 201, 640
Wisconsin	53, 784, 000	4, 302, 720	58, 086, 720
Wyoming	4, 692, 000	375, 360	5, 067, 360
Total	2, 500, 000, 000	200, 000, 000	2, 700, 000. 000

[2] Charts showing State title XX allotments for fiscal years 1980 and 1981 are on a later page.

ALLOTMENT LIMITATION FISCAL YEAR 1981—FEDERAL ALLOTMENT

State	Social services	Child day care	Total
Alabama	$46, 332, 057	$3, 432, 004	$49, 764, 061
Alaska	4, 969, 797	369, 614	5, 359, 411
Arizona	29, 146, 356	2, 158, 989	31, 305, 345
Arkansas	27, 066, 241	2, 004, 907	29, 071, 148
California	276, 036, 044	20, 447, 115	296, 483, 159
Colorado	33, 058, 950	2, 448, 811	35, 507, 761
Connecticut	38, 370, 669	2, 842, 272	41, 212, 941
Delaware	7, 218, 490	534, 703	7, 753, 193
District of Columbia	8, 345, 218	618, 164	8, 963, 382
Florida	106, 407, 722	7, 882, 054	114, 269, 776
Georgia	62, 948, 204	4, 662, 829	67, 611, 033
Hawaii	11, 106, 321	822, 691	11, 929, 012
Idaho	10, 871, 071	805, 264	11, 676, 335
Illinois	139, 206, 659	10, 311, 604	149, 518, 263
Indiana	66, 538, 876	4, 928, 806	71, 467, 682
Iowa	35, 857, 199	2, 656, 088	38, 513, 287
Kansas	29, 072, 066	2, 153, 486	31, 225, 552
Kentucky	43, 310, 939	3, 208, 218	46, 519, 157
Louisiana	49, 105, 542	3, 637, 447	52, 742, 989
Maine	13, 508, 358	1, 000, 619	14, 508, 977
Maryland	51, 297, 090	3, 799, 785	55, 096, 875
Massachusetts	71, 481, 528	5, 295, 668	76, 787, 196
Michigan	113, 774, 792	8, 427, 762	122, 202, 554
Minnesota	49, 625, 570	3, 675, 969	53, 301, 539
Mississippi	29, 765, 437	2, 204, 847	31, 970, 284
Missouri	60, 174, 719	4, 457, 386	64, 632, 105
Montana	9, 719, 579	719, 969	10, 439, 548
Nebraska	19, 377, 250	1, 435, 352	20, 812, 602
Nevada	8, 171, 875	605, 324	8, 777, 199
New Hampshire	10, 784, 400	798, 844	11, 583, 244
New Jersey	90, 720, 198	6, 720, 015	97, 440, 213
New Mexico	15, 006, 535	1, 111, 595	16, 118, 130
New York	219, 749, 157	16, 277, 716	236, 026, 873
North Carolina	69, 052, 346	5, 114, 989	74, 167, 335
North Dakota	8, 072, 822	597, 987	8, 670, 809
Ohio	133, 090, 134	9, 858, 528	142, 548, 662
Oklahoma	35, 659, 093	2, 641, 414	38, 300, 507
Oregon	30, 260, 701	2, 241, 535	32, 502, 236
Pennsylvania	145, 484, 145	10, 776, 603	156, 260, 748
Rhode Island	11, 576, 823	857, 543	12, 434, 366
South Carolina	36, 129, 595	2, 676, 266	38, 805, 861
South Dakota	8, 543, 324	632, 839	9, 176, 163
Tennessee	53, 946, 759	3, 996, 056	57, 942, 815
Texas	161, 134, 524	11, 935, 891	173, 070, 415
Utah	16, 182, 790	1, 198, 725	17, 381, 515
Vermont	6, 029, 853	446, 656	6, 476, 509
Virginia	63, 740, 628	4, 721, 528	68, 462, 156
Washington	46, 728, 269	3, 461, 353	50, 189, 622
West Virginia	23, 029, 831	1, 705, 913	24, 735, 744
Wisconsin	57, 933, 644	4, 291, 381	62, 225, 025
Wyoming	5, 249, 810	388, 876	5, 638, 686
Total	2, 700, 000, 000	200, 000, 000	2, 900, 000, 000

The conference agreement on H.R. 3434 included several complicated compromises between the House position, which called for increased Federal spending, and the Senate position which sought to reduce the level of spending. On one major, costly item—grants to States for social service programs—conferees accepted the Senate's $200 million cut to $2.7 billion for 1980. Federal matching grants to States were authorized at $2.7 billion, compared with the $2.9 billion for fiscal year 1979 and the House position of $3.1 billion for 1980. The final bill did authorize future growth by gradually indexing the ceiling with the Consumer Price Index (CPI) for the next 6 years as follows:

—$2.7 billion in fiscal year 1980.
—$2.9 billion in fiscal year 1981.
—$3 billion in fiscal year 1982.
—$3.1 billion in fiscal year 1983.
—$3.2 billion in fiscal year 1984; and
—$3.3 billion in fiscal year 1985.

The basic title XX program of grants to States supports social services for individuals and families. Legislated service goals include preventing abuse and neglect of children and adults, helping individuals achieve economic self-sufficiency, and preventing inappropriate care in institutions. At least 50 percent of the Federal funds must be used for services to public assistance recipients while the remaining funds may be used for other low-income individuals. Services most frequently offered through title XX State plans include day care, homemaker, counseling, and protective services.

Training

Public Law 96–272 also placed a limitation on Federal matching funds for training and mandated a formula for allocating such limitation. This limitation on training funds was in response to a congressional perception that title XX training expenditures were increasing too rapidly since these training funds were open-ended. For fiscal year 1980, the formula for Federal matching funds, as published on August 27, 1980 (vol. 45, Federal Register, p. 57175) is limited to the highest of:

—Four percent of the State's allotment for title XX social services.
—The actual amount of Federal matching for the amounts spent by the States for training in fiscal year 1979; and
—The amount payable to the State with respect to State appropriations made prior to October 1, 1979, for fiscal year 1980, limited to $6 million distributed proportionally among affected States.

On the basis of the formula alone, the maximum entitlement for personnel training or retraining would be $143,381,730. However, the supplemental appropriations bill for fiscal year 1980 limited the funding to $75 million. The Federal allotment for training to each of the 50 States and the District of Columbia was reduced proportionally as follows:

State:	*Allotment*
Alabama	$963, 582
Alaska	109, 101
Arizona	1, 077, 004
Arkansas	1, 400, 935
California	6, 147, 747
Colorado	683, 921
Connecticut	5, 955. 672
Delaware	151, 965
District of Columbia	234, 438
Florida	2, 207, 142
Georgia	1, 443, 981
Hawaii	233. 721
Idaho	223, 779
Illinois	2, 936, 505
Indiana	1, 391, 864
Iowa	751, 803
Kansas	607, 408
Kentucky	1, 484, 294
Louisiana	1, 330, 088
Maine	630, 229
Maryland	1, 080, 838
Massachusetts	2, 148. 729
Michigan	2, 383, 918

State:	*Allotment*
Minnesota	1,038,017
Mississippi	705,612
Missouri	1,253,728
Montana	616,368
Nebraska	407,628
Nevada	169,775
New Hampshire	221,699
New Jersey	1,913,877
New Mexico	593,974
New York	7,915,891
North Carolina	2,162,524
North Dakota	280,125
Ohio	2,794,438
Oklahoma	754,584
Oregon	620,469
Pennsylvania	3,990,130
Rhode Island	439,956
South Carolina	751,034
South Dakota	179,917
Tennessee	1,122,620
Texas	4,724,244
Utah	635,448
Vermont	403,237
Virginia	1,547,102
Washington	1,235,407
West Virginia	1,244,308
Wisconsin	1,414,640
Wyoming	284,584
Total	75,000,000

The passage of H.R. 3434, which necessitated the new reimbursement formula, set limits on Federal matching payments for State training of social service workers for fiscal years 1980 and 1981, required that Federal matching funds be allowed only for State training programs that have been approved by the Department of Health and Human Services (HHS).

IV. TRANSPORTATION—UMTA

A. Accessibility Issue Rekindled

Debate over making mainline bus and rail systems accessible was rekindled in 1980, as Congress considered amendments to give local transit systems the option of establishing specialized transportation services to meet the needs of the handicapped.

Separate measures approved by the House and Senate would have authorized transit authorities to submit a plan to the U.S. Department of Transportation for meeting the needs of the handicapped through specialized transportation services (such as vans and minibuses).[3] If a plan met guidelines outlined in the amendments and was approved by the Secretary, the transit authority would be deemed in compliance with Federal accessibility requirements, including section 504 of the Rehabilitation Act of 1973.

[3] The House Public Works and Transportation Committee adopted a local option amendment offered by Representative James Cleveland to H.R. 6417 on May 14 (H. Rept. 96–963). When considered by the full House, the local option provision was modified before the bill passed the House on December 4. The Senate's local option provision was adopted as an amendment to S. 2720. Offered by Senator Edward Zorinsky, it was approved by the Senate on June 25.

In the final days of the 96th Congress, a compromise local option provision which reconciled differences between the House and Senate measures died as Congress adjourned before the Senate voted on the compromise.

B. Appropriations Legislation

An amendment addressing the accessibility issue was, however, inserted into the 1981 transportation appropriations measure (H.R. 7831).

Before reporting H.R. 7831, the Senate Committee on Appropriations adopted an amendment prohibiting the Department of Transportation from using any of its funds to "compel local transit authorities to purchase wheelchair lifts to comply with section 504 of the Rehabilitation Act of 1973." The amended legislation was reported on September 9.

When the bill was considered by the full Senate on September 18, Senator Robert Dole of Kansas offered an amendment to stipulate that funds could be used to compel transit authorities to purchase wheelchair lifts under the following circumstances:

(1) To the extent required under the Senate version of the aforementioned local option amendment, and

(2) Where transit authorities have elected to purchase lifts.

The provision was retained in the bill that passed Congress, and was signed into law (Public Law 96–400).

Subsequent to the bill's passage. Secretary of the U.S. Department of Transportation Neil Goldschmidt, asked his General Counsel for an opinion on the amendment's implications. The resulting opinion, transmitted on October 27, 1980, clarified the Department's position on the amendments as follows:

> . . . The Department is authorized to use funds under the 1981 Appropriations Act to plan and execute programs to compel the purchase of lifts in accordance with the Department's 504 regulation until a recipient has submitted and the Secretary has approved an alternative transportation program meeting the requirements of the Zorinsky amendment (Senate version of the local option amendment). At that point, the Department would only be authorized to use appropriated funds to compel lifts at the levels provided for in a recipient's approved program. It should be noted, however, that even if the Department approved a recipient's alternative program under the Zorinsky amendment, the recipient would face the risk of a court challenge to any purchases of inaccessible buses. Such a challenge would be based on the argument that section 324 was only intended to limit the expenditure of funds by the Department and did not overturn the Department's 504 regulation.

Chapter 7

HOUSING

CHAPTER HIGHLIGHTS

The cost of owning and maintaining a household continued to climb during 1980. The Consumer Price Index rose approximately 13.5 percent with energy and housing prices posting the greatest increases. Energy prices alone rose 31 percent and housing prices rose 15.7 percent.[1]

Such increases continued to place a significant burden on the elderly to maintain homes and locate alternative housing.

Construction and land costs continued to plague the development of Federal housing programs. Sponsors and developers were faced with cutting back in the design of projects to meet the escalating costs of land and materials.

Although the Congress passed the Housing and Community Development Amendments of 1980 (Public Law 96–399), these amendments did little to change or expand the existing array of housing and subsidy programs. The talk of "housing block grants" by the new administration guarantee a comprehensive scrutiny, at the least, of the housing programs by the 97th Congress.

I. FEDERAL HOUSING PROGRAMS FOR THE ELDERLY

Federal housing programs for the elderly under the Department of Housing and Urban Development (HUD) were afflicted with the problems that all housing programs, public as well as private, experienced during 1980: How to finance, construct, and maintain decent and affordable housing for the low income when faced with today's inflated housing costs. Climbing interest rates put strains on sponsors and continually rising costs placed unprecedented demands on rent subsidy programs such as section 8. The declining availability of rental units in many communities put pressure on everyone, including sponsors, developers, and residents.

As elderly residents continued to seek decent and affordable housing alternatives, demands on Federal housing programs grew. Waiting lists for section 202 projects and congregate housing gave evidence to this demand. More and more elderly occupied units in all forms of public housing as shown by the following HUD listing of housing programs.

[1] U.S. Department of Labor, Bureau of Labor Statistics.

SUMMARY OF HUD HOUSING UNITS FOR THE ELDERLY

[All figures represent number of projects/units currently insured by FHA unless otherwise noted]

Section No., and program	Status	Number of projects	Number of units	Value	Approximate number of elderly units	Percent of elderly units	Report period
Construction projects:							
Title II: Low-income public housing	Active	10,750	1,200,000	NA	[1] 552,000	46±	Cumulative through Sept. 30, 1979.
202: Direct loans for housing for elderly and handicapped	Inactive [2]	330+	45,275	574,580,000	45,275	100	Cumulative through 1972.
	Active [3]	1,211	91,716	3,325,074,000	87,522	95	May 31, 1980.
231: Mortgage insurance for housing for elderly	do	477	64,116	1,082,966,264	64,116	100	Cumulative through December 1979.
221(d)(3): Multifamily rental housing for low and moderate income families.	do	3,417	346,383	5,337,537,561	55,602	7	Do.
221(d)(4): Multifamily rental housing for low and moderate income families.	do	3,874	447,938	8,939,941,234			
235: Homeownership assistance for low and moderate income families.	Inactive [2]	[4] 472,059	473,032	8,456,660,790	([5])	([5])	Cumulative review program through May 1980.
	Active	40,862	40,893	1,352,920,895	([5])	([5])	
207: Multifamily rental housing	do	2,639	285,108	3,937,745,205	3,421	1.2	Cumulative through December 1979.
236: Rental and cooperative assistance for low income families	Inactive	4,052	434,645	7,479,970,182	53,799	12	Cumulative through December 1978.
202/236: 202/236 conversions	do	182	28,306	482,032,750	28,306	100	Do.
232: Nursing homes and intermediate care facilities	Active	1,271	[6] 145,262	1,581,565,981	145,262	100	Cumulative through December 1979.
Nonconstruction programs:							
8: Low-income rental assistance:							
Existing [7]	do	9,446	821,418	NA	240,742	29	Cumulative through May 31, 1980.
New construction [7] [8]	do	8,393	538,561	NA	290,447	54	Do.
Substantial rehabilitation [7] [8]	do	1,650	112,828	NA	40,107	35	Do.
312: Rehabilitation loans	do [9]	75,913	NA	780,225,000	NA	([10])	Cumulative through Sept. 30, 1979.
23: Low rent leased housing	Inactive [2]	NA	163,267	NA	54,000+	35±	Cumulative through December 1975.

[1] Data does not indicate how many of these units are designed specifically for the elderly.
[2] Figures for original program reported through program revision.
[3] Figures for revised sec. 202/8 represent cumulative project reservations as of May 31, 1980.
[4] Figures represent number of mortgages.
[5] Figures not currently available.
[6] Beds.
[7] Figures represent cumulative fund reservations through reporting date.
[8] Figures do not include sec. 8 commitments attached to sec. 202/8 fund reservations.
[9] Figures represent loan commitments only.
[10] Approximately 25 percent of loans.

Source: This table was compiled by the Office of the Special Assistant for Elderly Housing and Special Programs, with the assistance of the Housing Budget Division, Management Information Systems Division, Multifamily and Single Family Insured Branches, and the Data Systems and Statistics Branch in the Office of Housing.

A. Section 202 Housing

Section 202 of the Housing Act provides for direct, low-interest construction and permanent financing loans for the development of housing projects especially designed for the elderly and handicapped. By law, sponsors are required to be nonprofit organizations and associations and have included religious institutions, union groups, community-based organizations, cooperatives, and fraternal organizations.

By the end of fiscal year 1980, HUD reported that 734 projects with approximately 69,000 units were approved under the 202 program, since the program's renewal in 1974. Of these projects, approximately 247 were completed with occupants in about 26,200 units.

A gross loan limitation level of $830 million was approved by the Congress for the 202 program in fiscal year 1980. HUD estimated that this amount would support approximately 18,000 units of housing. Earlier projections had shown $830 million to support approximately 20,000 units in 1980, but inflation and soaring costs decreased this estimate during the year.

During consideration of the budget and appropriations for fiscal year 1981, Senator Lawton Chiles offered motions to increase the gross loan limitation to $880 million which, according to Congressional Budget Office (CBO) projections, would be necessary to at least hold the number of units at the 1980 level. In a letter to the chairman of the Appropriations Committee's Subcommittee on Banking, Housing, and Urban Affairs, Senator Chiles described the section 202 program "as a tremendously successful program that is free of the high costs and management problems of other Federal housing programs." [2]

The Senate Appropriations Committee approved the $50-million increase in the Senate's fiscal year 1981 HUD appropriation bill (H.R. 7631). However, the House bill contained only $830 million and the Senate and House conferees agreed to split the difference leaving the total section 202 program with a loan limitation level of $855 million for fiscal year 1981 (Public Law 96–526). This increase was almost entirely negated by HUD when it carried out a congressionally mandated 2 percent cut in the overall HUD budget. The targets of the 2-percent cuts were left to the discretion of the Secretary who, along with OMB, decided upon a $24-million cut in the 202 program for fiscal year 1981.

The 202 program's loan limitation for fiscal year 1981 was thus left at approximately the 1980 level which could mean a substantial reduction in the number of units for the section 202 program.

B. Public Housing

The conventional public housing program under the Housing Act supports the greatest number of federally funded housing units. Elderly residents are eligible for units in most public housing units and some projects are especially designed for their occupancy.

According to HUD, there are approximately 1 million units of public housing in the United States of which 44 percent are occupied

[2] Letter to Senator William Proxmire, chairman of Subcommittee on Banking, Housing, and Urban Affairs, Senate Appropriations Committee, from Senator Lawton Chiles, chairman, Senate Committee on Aging, Aug. 18, 1980.

by an elderly person (age 62 and over). During 1980, 15,200 units of public housing were completed for occupancy and 5,200 were filled by elderly residents.

Public housing has experienced serious problems over the past few years. Reservations have decreased significantly due to problems with receiving sufficient operating subsidies to cover the program, a preference for section 8 subsidies, and difficulties in locating acceptable sites due to increasing land costs and rejection by communities.

One particular obstacle for low-income elderly in obtaining public housing units was removed by the 1980 amendments to the Housing and Community Development Act (Public Law 96–399). This obstacle previously had been a requirement that public housing have a mixture of incomes among the residents. As described in the following section of this chapter, this "tenant selection criteria" had resulted in low-income elderly being denied a unit in deference to a moderate-income person so that the project could meet its income mixture requirement. Under the new law, the Secretary of HUD can waive this criteria for public housing projects especially designed for the elderly.

C. Section 8 Rent Subsidies

Since 1974, section 8 of the Housing Act has provided for rent subsidies on behalf of residents of public housing as well as private projects. Assistance can be provided for units in existing housing, new construction or for rehabilitated units. The resident pays 15 to 25 percent of his or her income for rent and HUD pays the owner the difference between the resident's payment and contract rent.

Those residents eligible for assistance under section 8 must have incomes below 80 percent of the median income in their area. In the Senate's version of the Housing and Community Developments Amendments of 1980 (S. 2719), the income eligibility level was decreased to 65 percent of median income. This change was deleted by the House and Senate conferees in the final bill (Public Law 96–399). It is expected that efforts to reduce the eligibility level to as low as 50 percent will be attempted in the 97th Congress.

According to HUD, 212,000 units of section 8 were reserved in 1980. Of these units, approximately 34 percent (or 73,000) were occupied by elderly persons.

D. Section 515

Section 515 of the Housing Act authorizes the Farmers Home Administration (FmHA) to provide low-interest loans to sponsors of rental projects in rural areas. FmHA has an agreement with HUD which assures that 10,000 units of 515 housing will receive section 8 assistance for each year. In addition, FmHA has a separate rental assistance program which provides rent subsidies to eligible tenants.

Since its beginning in 1970, section 515 has supported approximately 224,000 units of which 40,000 were initiated in 1980. Estimates of the National Rural Housing Coalition show that about 50 percent of the 224,000 units are occupied by elderly persons. Elderly and handicapped persons are required to receive priority under the 515 program.

E. Congregate Services

In 1978, the Congress created the congregate housing services program (CHSP) as a part of the Housing and Community Development Amendments of 1978 (Public Law 95–557). Under this program, HUD is authorized to make grants to public housing projects and section 202 projects to assist the projects in providing "supportive services" to the more frail elderly and handicapped residents. The law mandates that supportive services must include "full meal service" and may include "housekeeping aid, personal assistance, and other services essential for maintaining independent living."

Housing projects are required by law to coordinate services under CHSP with the local area agency on aging and guarantee that no services provided to eligible residents are duplicative of services already accessible to the participants. Former Secretary of HUD, Moon Landrieu, described the programs as a "cost effective means of enabling handicapped or temporarily disabled elderly individuals to remain in their own homes. It is an alternative to costly and unnecessary institutionalization that at the same time maintains the dignity of the individual." [3]

During 1980, HUD made the second round of awards under the congregate services program. However, only $6 million of the $10 million 1980 appropriation was obligated to existing projects. The remaining 1980 funds, which were intended for new construction, were still not obligated by the first of 1981. The holdup appeared to be tied to the administration's decision in the 1982 budget request to rescind the 1981 budget for congregate housing services.

The $6 million awards went to housing projects across the country to develop congregate services programs. Those projects included:

Project:	*Location*
Golden Age Village	Monterey Park, Calif.
Posada de Colores	Oakland, Calif.
Cathedral Plaza	Denver, Colo.
Oakville Home for the Independent Living	Hartford, Conn.
Federation Towers	Miami Beach, Fla.
Martin Fine Villas	Miami, Fla.
The Protectory	Lawrence, Mass.
Ravoux Plaza	St. Paul, Minn.
Kingsbury Terrace	St. Louis, Mo.
Bell House	Greensboro, N.C.
Aster Dowdy Towers	High Point, N.C.
New Horizon Manor	Fargo, N. Dak.
Elderly Care Center	Laguna, N. Mex.
Channelwood II	Akron, Ohio
Pioneer Plaza	Tulsa, Okla.
Opportunities Housing for the Elderly	Philadelphia, Pa.
Redbird-War Eagle Elderly	Wagner, S. Dak.
Small Group Home	Oshkosh, Wis.

[3] News release, U.S. Department of Housing and Urban Affairs, Office of Public Affairs, Sept. 25, 1980.

II. HOUSING AND COMMUNITY DEVELOPMENT AMENDMENTS OF 1980

The Housing and Community Development Amendments of 1980 (Public Law 96–399) contributed little to the expansion or change of Federal housing programs. Major changes were proposed—such as the establishment of a new moderate-income program and the lowering of the income eligibility level for section 8 rent subsidies—but were eventually contested, defeated, and struck from the final bill approved by the Congress.

Several changes in the 1980 amendments do contain provisions which directly affect the elderly resident. These changes are described in the following pages.

A. Change in the Tenant Section Criteria

Public Law 96–399 amends the Housing Act's tenant selection criteria which requires that public housing projects have an income mixture of residents. The new language gives the Secretary of HUD authority to waive this requirement for projects especially designed for the elderly in order to avoid rejection of low-income elderly as tenants. Senator David Durenberger, sponsor of the amendment, explained the rationale behind his amendment:

> There are long lists of low-income elderly waiting to get into the projects. But in order to qualify under the mix provisions of the law, these projects must provide housing to the elderly nonpoor in order to accommodate the low-income or elderly poor.[4]

B. Prepayment of Sections 514 and 515 Loans

The new law contains a provision which repeals the Housing Act's restrictions on the prepayment of loans under the sections 514 and 515 rural housing programs. The result of allowing prepayments, prospectively as well as retroactively, permits owners of 514 and 515 projects to sell property whose units were intended as housing for low- and moderate-income persons.

During debate on this issue, concern was expressed that the displaced elderly tenants of such units could encounter severe hardships when faced with locating alternative housing. In a letter to the conferees for the Housing and Community Development Amendments of 1980, Senator Lawton Chiles and Representatives Claude Pepper and Edward Roybal expressed their concern:

> "* * this provision prevails in conference, we urge that reasonable provisions be contained in the law which assure that in those projects whose loans are prepaid, the elderly tenants are not deprived of their units or at least are assured of alternative housing in the area. In many rural communities across the country, reasonably priced rental units are scarce and

[4] Durenberger, David. Amendment to the Housing Act of 1974. Remarks in the Senate. Congressional Record, vol. 123, June 21, 1980, p. 7720.

the sections 514 and 515 programs have been a successful source for decent and affordable housing for many elderly. Recognizing that this was the precise intent of the law, we would hope that the capability of providing for low- and moderate-income elderly will not be thwarted.[5]

In response to such concern, the conferees agreed to allow prepayments but with the following qualifications:

(1) If any loan which was made or insured under section 514 or 515 pursuant to a contract entered into before December 21, 1979, is prepaid or refinanced on or after the date of enactment of the Housing and Community Development Act of 1980, and tenants of such housing and related facilities financed with such loans are displaced due to a change in the use of the housing, or to an increase in rental or other charges, as a result of such prepayment or refinancing, the Secretary shall provide such tenants a priority for relocation in alternative housing assisted pursuant to this title.

(2) The Secretary of Agriculture shall conduct a study of, and report to the Congress not later than 6 months after the date of enactment, any adverse effects the amendments made by subsection (a) may have on housing, particularly for the elderly and persons of low income.[6]

C. Section 312 Rehabilitation for Congregate Housing and SRO's

The 1980 amendments expand the section 312 rehabilitation program's maximum loan amounts for residential property to include congregate housing facilities in which all units do not contain kitchen facilities but have a central dining area and facilities in which all units do not contain bathrooms or kitchens, commonly referred to as "single-room-occupancies or SRO's." These facilities which often house elderly persons are therefore eligible for rehabilitation and improvement loans under the section 312 program at a rate of $25,000 per unit in congregate housing and $15,000 per unit in SRO's.

D. Minimal Protection for Condominium Dwellers

What was originally intended to protect tenants whose dwellings were faced with conversion to condominiums and cooperatives and protect condominium and cooperative owners from unconscionable recreational leases was watered down to very minimum protection by the conferees on the Housing and Community Development Amendments of 1980 (Public Law 96–399).

The original legislation, introduced in the Senate by Senators Dick Stone and Lawton Chiles (S. 612), and later incorporated into Senator Williams' housing reauthorization bill (S. 2719), provided for a greater degree of protection, especially for tenants whose dwellings

[5] Letter to conferees on the Housing and Community Development Amendments of 1980 (S. 2719) from Senator Lawton Chiles, chairman of the Senate Committee on Aging, Representative Claude Pepper, chairman of the House Committee on Aging, and Representative Edward Roybal, chairman of the Subcommittee on Housing and Consumer Interests, House Committee on Aging, Sept. 12, 1980.

[6] Section 514 of Public Law 96–399.

face conversion. The Senate bill had provided for specific time and condition responsibilities for developers about notifying tenants whereas the conference version of the legislation merely calls for "adequate notice."

Other provisions contained in the new title VI (Condominium and Cooperative Conversion Protection and Abuse Relief) are described below:

—The new title requires that developers provide adequate notice to tenants and give them the first opportunity to buy the unit in the converted building. However, the conferees point out "that the Congress believes it is the responsibility of State and local governments to provide for such notice and opportunity to purchase in a prompt manner . . . the Congress has decided not to intervene, and therefore leaves this responsibility to the State and local governments to be carried out." [7]

—The conferees express the intent of Congress that lending by federally supported institutions for the purpose of converting rental dwellings into condominiums or cooperatives should be discouraged when "there are adverse impacts on the housing opportunities of the low- and moderate-income and the elderly and handicapped individuals involved." [8]

—The new law provides judicial remedy for owners of condominiums and cooperatives who are affected by long-term leasing arrangements for recreational facilities. However, such action can only be brought when there is a vote of agreement by two-thirds of the owners association. To seek alleviation, the owners must prove that leases are unconscionable. According to the law, an unconscionable lease is one with all of the following characteristics:

(1) It was made in connection with a cooperative or condominium project.

(2) It was entered into while the cooperative or condominium owners' association was controlled by the developer either through special developer control or because the developer held a majority of the votes in the owners' association.

(3) It is for a period of more than 21 years or is for a period of less than 21 years but contains automatic renewal provisions for a period of more than 21 years.

(4) It contains an automatic rent increase clause; and

(5) It was entered into prior to June 4, 1975.

—Title VI provides for termination of "self-dealing" contracts which have been entered into after the effective date of the title. A self-dealing contract is one which relates to operation, maintenance, or management of a conversion project or of any property serving the owners in such project. Termination of such contracts may occur at any time without penalty within a 2-year period beginning on the date on which special developer control is terminated or the developer owns 25 percent or less of the units in the converted project, whichever comes first.

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[7] U.S. Congress. Senate Committee on Banking, Housing, and Urban Affairs and House Committee on Banking, Finance and Urban Affairs, "Conference Report (to accompany H.R. 2719)" report No. 96–1420, Sept. 26, 1980, p. 167.

[8] Ibid., p. 163.

The full impact of "condominium conversion" on the elderly tenants is still cloudy. Some argue that conversion has contributed significantly to the decline in rental units for the elderly. The Department of Housing and Urban Development in a congressionally mandated report on conversion states:

> It has been reported that elderly persons are more likely than others to feel the pressure of conversion and to be anxious about the prospects of relocation or about having to make a substantial investment in purchasing their unit. Some have suggested that elderly tenants who ultimately purchase their units are "distressed purchasers," who buy because they have no other choice. There is some support for these contentions, but it appears as if not wanting to move is a more persuasive explanation than the unavailability of alternative housing or the pressures and anxieties associated with purchasing.[9]

Whatever the extent of the effects of conversion, it is expected that the 97th Congress will have to address the issue more extensively than did the 96th Congress.

III. INVESTIGATION OF FEDERALLY FUNDED HOME REHABILITATION PROGRAMS FOR THE ELDERLY IN NEW MEXICO

Continuing its efforts to monitor the effectiveness of federally funded projects which directly impact upon the health and welfare of senior citizens, the U.S. Senate Special Committee of Aging held hearings in Santa Fe, N. Mex., and Washington, D.C., to take testimony and examine charges of fundamental abuses in home rehabilitation programs for the elderly.

The investigation was requested by New Mexico Senator Pete V. Domenici, after complaints from elderly citizens first surfaced at an earlier hearing on April 11, 1980. At that time senior citizens from rural communities of San Miguel, Mora, and Rio Arriba Counties met with Senator Domenici to discuss the "Rural Elderly—the Isolated Population: A Look at Services in the 80's." Federal programs initially reviewed included weatherization, energy assistance, and housing rehabilitation. Because of the magnitude of dissatisfaction in the overall effectiveness and ultimate performance of these programs expressed by many rural elderly, Senator Domenici asked for and received permission to proceed with a preliminary investigation to determine the extent of these complaints.

The committee secured the services of an investigator, Dr. Martin La Vor, who submitted an initial investigative report on June 27, which documented the following abuses:

—Federal funds utilized to improve the home and lives of poor and elderly rural New Mexicans have been committed but have not in many cases reached the targeted population.

—Work which actually has been started is of poor quality and generally incomplete.

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[9] U.S. Department of Housing and Urban Development. Office of Policy Development and Research. "The Conversion of Rental Housing to Condominiums and Cooperatives: A Study of Scope, Causes, and Impacts." Washington, D.C., June 1980, p. IX–8.

—There is evidence of "nepotism" involved in the awarding of grants, distribution of funds, and selection of contractors.
—Farmers Home Administration (FmHA) and Community Services Administration (CSA) guidelines and procedures for awarding grants—are "so loose," they appear to be designed for misuse.
—Official records and reports were incomplete and many times unavailable.

Acting on the investigator's findings, the full committee voted 8–0, to authorize subpenas and pursue the investigation. The scope of the probe was expanded to include all federally funded programs in New Mexico actively involved in assisting the elderly to rehabilitate their homes.

Conducting the October 8 hearings in Santa Fe were Chairman Lawton Chiles, and Senators John Melcher and Pete Domenici. Witnesses included elderly recipients of housing rehabilitation grants, contractors, and State and local program administrators from the FmHA.

The second investigative report dated October 8, revealed the following inconsistencies in administering FmHA programs:

—FmHA officials continually referred to funding under section 504 as "so small—only $24 million—that it falls through the cracks."
—Department of Agriculture spokesmen acknowledged that the Inspector General, "rarely evaluates" section 504 programs separately; in point of fact—only three audits for all section 504 programs in the entire United States have been undertaken during the last 3 years.
—Onsite inspection of rehabilitated homes are rarely undertaken by FmHA personnel. Case files are merely "spot checked," to determine if Federal funds are spent properly.
—FmHA rules and guidelines were neither enforced nor followed in many cases, and in some, the actual guidelines were not known or understood by officials employed to enforce them.
—Federal funds were disbursed to contractors and their work certified as "complete, family happy," even though onsite inspections by Aging Committee investigators refuted these contentions.
—FmHA officials admitted to personal intervention on behalf of "friendly" contractors who were in actuality family members of FmHA employees.
—Shoddy workmanship, inferior materials, unqualified contractors were the rule not the exception.
—Programs funded by different agencies and authorized by different laws appear to be used for the same purposes.
—Funds provided by one program were used to "correct or redo" work already completed by another agency.

Commenting on information on abuses uncovered by the investigation and hearings, Senator Domenici offered this statement:

> These examples of abuse and improper administration of home rehabilitation programs are but a few of many exposed by our investigations. They vividly illustrate the frustrating barriers which have been erected between the elderly and

agencies of the Federal Government mandated to assist the poor, the handicapped, and the aged.

Money alone is not enough. We must have individuals administering these programs who care for human dignity. We must have programs which work.

It is incumbent upon the Congress and the appropriate departments of the Federal Government to reevaluate procedures governing section 504 and take immediate corrective action.[10]

The second investigative report contained a series of proposed recommendations for the Special Committee on Aging and the various agencies involved to consider. These options included:

—*A complete review by the General Accounting Office (GAO) of all housing rehabilitation programs serving the elderly.* The GAO would explore the need to consolidate the maze of separate authorizations into a more coherent service delivery mechanism. The findings of the GAO study would be shared with appropriate authorizing committees of Congress.

—*Expedite investigative procedures.* Inspectors General for the Departments of Agriculture, Housing and Urban Development, Health and Human Services, Energy, and the Community Services Administration, should develop streamlined methods to insure that any evidence of criminal activity uncovered through audits are promptly investigated and referred to the U.S. attorney for prosecution.

—*Bridge gap between audit and investigation.* There is an obvious gap between an agency's audit division which corrects systematic deficiencies and its investigative division charged with prosecuting criminal conduct. Some problems go uncorrected because they fall into the middle ground between the two. Congress should enact legislation to eliminate this gap and strengthen project accountability.

—*Joint Inspector General audits on a statewide basis.* To detect duplication of projects and possible double payments for the same work, coordinated audits on a statewide basis by the various funding agencies is absolutely essential. Coordination with State auditors—where States have similar programs—should be mandatory.

—*Coordination of vulnerability assets.* If not already implemented, Inspectors General should coordinate the risk analysis for programs or vulnerability assessments. This will afford the opportunity of eliminating duplicate projects and duplicate payments for the same work under similar programs.

—*Increase audit team effectiveness.* It is imperative that elderly recipients of benefits trust officials with whom they lodge complaints. Without this trust, disclosure of program deficiencies and abuse is not possible. Many times the only person at home is an elderly woman. Audit teams should include women. Also, in some

[10] Special Committee on Aging hearing, Santa Fe, N. Mex., Oct. 8, 1980.

areas of the country, minority representation on audit teams is necessary.

—*Mandatory onsite inspection.* Any program audit must include onsite inspections of actual work performed together with a review of documents and files.

—*Selective prosecution.* Prosecution of documented cases involving fraud is necessary to establish the integrity of federally funded projects within section 504. Individuals who attempt to receive Government moneys while continuing to do shoddy work must be put on notice that failure to meet specific contractural obligations will not be tolerated.

Senator Domenici concluded the October 8 hearings of the committee with this assessment of Government-funded home rehabilitation programs:

> After participating in these hearings and interviewing many officials in responsible Government positions as well as receiving reports from others not directly involved, one must conclude that our findings in New Mexico are not unique to this State. There is a very real and distinct possibility that similar problems can be found in home rehabilitation projects in other States.
>
> My conclusion finds support in the extensive reviews completed on a national basis with respect to the HUD rehabilitation programs which are quite similar in many respects to the 504 program.
>
> A summary of HUD survey entitled, "Special Operations Survey Community Development Block Grant Rehabilitation Activities," indicates many of the same problems identified in our New Mexico investigation exist nationwide in similar programs administered by HUD.

Following the October 8 hearings, Senator Domenici asked officials of the Farmers Home Administration office in Washington, D.C., to meet with Aging Committee staff members to discuss the ramifications of sworn testimony previously received and review the procedures FmHA intended to take to insure that:

(a) Problems focused on in New Mexico do not exist elsewhere in the program.

(b) These problems will not occur elsewhere.

(c) Corrective action by FmHA to properly repair those homes which received incomplete or shoddy work.

Several weeks later Gordon Cavanaugh, Administrator of FmHA responded by letter to Senator Domenici's requests.

Administrator Cavanaugh outlined immediate steps to prevent further abuses. These modifications in FmHA procedures included:

—Assignment of another county supervisor to the office where the problem situation existed.

—An administrative notice sent all offices alerting staffs to the types of problems discovered, together with guidelines on ways to prevent future problems.

—Thorough audits of all FmHA section 504 grants programs by the Inspector General's office.

—Scheduling of an early 1981 training session by the FmHA national office for personnel administering section 504 programs.

Commenting on the question of necessary corrective action by FmHA to properly repair homes which received initially incomplete or shoddy work, the Administrator concluded:

> The FmHA has no legal basis to provide assistance to persons whose homes were not properly repaired unless the amount of the 504 grant originally provided was less than the $5,000 legal maximum or the family could not qualify for a 504 loan at 1 percent interest. Total grant assistance cannot exceed $5,000 and total loan or combination loan and grant cannot be more than $7,500.

Senator Domenici characterized the FmHA response as "inadequate, a useless exercise." The Senator further stated:

> I have to tell you that even though this is not a big program . . . I am concerned because a number of my constituents have had their expectations dashed by what I consider to be poor management at the local level by those who administer your (FmHA) program.
>
> When a private citizen is clearly hurt by the actions or inactions of a Federal agency . . . then I think these people have a right to expect a redress of their grievances. To date, I regret to say, Farmers Home has seemed strangely impotent in its efforts to locate resource needed to repair these homes.[11]

Because of FmHA's inaction Senator Domenici requested a second hearing. Called to testify in Washington, D.C., December 19, were: Hon. Thomas F. McBride, Inspector General of the Department of Agriculture; Hon. Gordon Cavanaugh, Administrator, Farmers Home Administration; Hon. Alex Mecure, Assistant Secretary for Rural Development, Department of Agriculture.

Senator Domenici convened the hearing with these words:

> The purpose of this hearing is to attempt to get some real answers from you gentlemen at the highest level.
>
> I am still not sure that you all understand and feel what we, who have seen these houses and have viewed this episode, feel.
>
> I thought you should come here and answer some questions and maybe we can once and for all put this behind us.

Under questioning by Senator Domenici, Agriculture officials acknowledged:

—Corrective action should have been taken when information of 504 program abuses is received. In matter of fact some 8 months expired before any criminal investigation was instituted.

—When an investigation reveals a disciplinary problem, there is a "semiparalysis" in the decision process because the Department of Agriculture will not take any action while charges are "pending."

—FmHA management and support staff have a serious "competency problem."

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[11] Special Committee on Aging hearing, Washington, D.C., Dec. 19, 1980.

—Department of Agriculture regulations and procedures were not followed by their own employees.
—There is no consistent monitoring of 504 projects.
—The 20 or more families whose homes are still not livable are "out in the cold." Department of Agriculture has no authority to make reparations. Current legislation does not permit indemnification for faulty construction.
—Bonding and State licensing of 504 prime contractors has not been required.
—There has been a breakdown in procedures protecting elderly grant recipients against fraud and forgery.
—There are not enough qualified FmHA building inspectors or onsite progress inspections to meet minimum New Mexico State requirements.

After listening to and questioning Department of Agriculture officials, Senator Domenici offered these observations:

> I don't want to abuse the hearing process. There is no way I want to have hearings on hearings on hearings on this issue. I have gone as high as I intend to go in the Department of Agriculture. I can say that if we don't find a way to at least offer some help, I clearly intend to take it out of some other program of the Department of Agriculture. I am going to do it.
>
> I am going to get money appropriated to help these poor people get at least some of what we have already paid for. It just seems to me that we are dancing all around this issue. We have to find a way to solve their problems.
>
> We hope we have solved the FmHA management problem. I am not sure we have, but at least we have pointed it up for you.

Senator Domenici concluded the last phase of his investigation with several suggestions for immediate attention and implementation by the Department of Agriculture and FmHA officials:

(1) A national audit of all 504 programs to be completed by April 1981.

(2) An early warning monitoring system of 504 projects to detect deficiencies before they are incorrectable.

(3) Use of State building inspectors to supplement FmHA personnel.

(4) A study of bonding and licensing procedures for prime 504 contractors.

(5) Preparation of a legal brief by the Department of Agriculture General Counsel to determine if 504 grant recipients who were defrauded have any legal redress.

Chapter 8

CONSUMER ISSUES

CHAPTER HIGHLIGHTS

Legislation to set minimum standards for medi-gap insurance policies sold to the elderly was signed into law, and the Department of Health and Human Services issued proposed regulations for a program of voluntary certification of medi-gap insurance policies. Reauthorization of the Federal Trade Commission reflected the views of some in Congress that the Commission had become too activist in recent years. Legislation to phase out ceilings on interest rates was also passed. It is anticipated many elderly with small savings accounts will realize much higher interest rates as a result.

I. MEDI-GAP INSURANCE PROTECTIONS BECOME LAW

On June 9, 1980, the President signed into law the Social Security Disability Amendments of 1980 (Public Law 96–265), which include provisions to establish a program of voluntary Federal certification of medi-gap health insurance policies by July 1, 1982, in those States which have not implemented a regulatory program meeting the law's minimum standards by that date.

Versions of the medi-gap amendments were introduced in the Senate in 1979, by Senators Chiles, Dole, and Baucus, and cosponsored by Senators Glenn, Bradley, Pryor, Cohen, Heinz, and Melcher, members of the Special Committee on Aging. Bills were introduced in the House of Representatives by Congressmen Brodhead, Pepper, Scheuer, and others.[1] The Senate considered and passed the amendments on January 30, 1980, as part of H.R. 3236, the Social Security Disability Amendments of 1980. Final approval came when the legislation was accepted by House conferees.

A. Provisions of the New Law

The new law sets minimum standards for private health insurance policies sold to supplement medicare and requires all States to implement a medi-gap regulatory program to enforce standards equal to or stronger than Federal standards by July 1, 1982. The Secretary of the Department of Health and Human Services, working with a panel of four State insurance commissioners appointed by the President, will determine if each State meets this requirement. In any State where

[1] See "Developments in Aging: 1979," part 1, pp. 155–165, for a discussion of these bills and other medi-gap actions during 1979.

the requirement is not met by July 1, 1982, the Secretary is authorized to certify all medi-gap policies sold in that State which meet the minimum Federal standards.

The new law also sets Federal criminal penalties (a fine of up to $25,000 and imprisonment for up to 5 years) upon conviction of: (1) Furnishing false information to the Secretary to obtain policy certification; (2) posing as a Federal agent to sell medicare supplemental policies; and (3) knowingly selling duplicative policies to medicare-eligible individuals. The sale of any medicare supplemental policies by mail would also be subject to the Federal penalties unless the policy in question had: (1) Been approved by the State under its own standards program or certified by the Secretary of the Department of Health and Human Services under the voluntary certification program, and (2) the State had not specifically disapproved the policy for sale in that State.[2]

The Department of Health and Human Services is required to provide all medicare beneficiaries with information on the types of private health insurance available to supplement medicare benefits. The Department also must prepare, in coordination with the Federal Trade Commission, an analysis of the effectiveness of different State approaches to regulation of medicare supplemental health insurance sales, with a report to Congress by January 1, 1982.

B. The Standards for Medi-Gap Policies

The minimum standards adopted by Congress are, in large part, those which were recommended by a special task force on medi-gap insurance formed by the National Association of Insurance Commissioners in 1978, after Senate Committee on Aging hearings had brought the issue to national attention. Minimum requirements for policy loss ratios (the ratio of premiums collected to benefits paid on a particular policy issue) were added by the legislation.

The law sets the following minimum standards for medi-gap health insurance policies sold to medicare-eligible persons:

—A policy must cover medicare part A (hospital insurance) coinsurance amounts for the 61st day of medicare coverage through the 90th day (currently $51 a day) and lifetime reserve period (currently $102 a day), and 90 percent of hospital charges beyond the lifetime reserve period up to 1 year.

—A policy must cover 20 percent of medicare part B (supplementary medical services) reasonable charges (the copayment amount set in the medicare program) up to a maximum amount of $5,000 per calendar year.

—A policy must have no more than a 6-month limitation on pre-existing condition restrictions.

—A policy must have a minimum loss ratio experience of 75 percent for group policies and 60 percent for individual policies.

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[2] Public Law 96–265 provides for exemptions from the penalties for certain specific types of policies and circumstances, such as group health policies of employers or labor organizations. The intent of Congress in these areas is expressed in the conference report on the legislation. U.S. Congress. "Social Security Disability Amendments of 1980." Conference report on H.R. 3236. House of Representatives report No. 96–944, May 13, 1980, p. 75.

—The buyer must have a right to return a policy without loss of premiums within 10 days of sale for agent-sold policies, and 30 days for policies sold through the mail.
—Potential buyers must be provided with an information pamphlet describing the different types of medi-gap insurance available at the time of application for purchase.[3]
—The potential buyer must be provided with an "outline of benefits" form which clearly states policy benefits, costs, limitations, rights to cancel, and comparison with medicare benefits at the time of application for purchase.

C. Implementation of the New Law

On October 30, 1980, the President appointed the commissioners of insurance from the States of Connecticut, Wisconsin, Arkansas, and Utah to serve with the Secretary of Health and Human Services on the panel to evaluate State medi-gap regulatory programs. Guidelines are expected to be provided to all States early in 1981 on information the panel will need to determine compliance with the law. The panel is required to report to Congress, on or before January 1, 1982, those States which are not expected to have an operational medi-gap regulatory program in place by the deadline of July 1, 1982.

Proposed regulations for implementation of the voluntary certification program were published in the Federal Register on January 21, 1981,[4] with a 60-day comment period. The proposal sets guidelines for use of a Secretarial "seal of approval" for insurance policies meeting approved State guidelines as well as those meeting minimum Federal standards.

Illinois, Florida, Maryland, Nebraska, and Tennessee are among the States which passed new medi-gap laws during 1980. Additional regulatory authority is being considered in Arizona, Virginia, New Jersey, and New York. Under the terms of the legislation, a majority of States may have met the minimum standards for regulation of medi-gap sales by the deadline date of July 1982. Federal voluntary certification programs would only be operational in States which do not meet the requirements.

Some States already have established a regulatory program which utilizes higher standards for policy content and sale than the minimums developed by the National Association of Insurance Commissioners or required by Federal law. This was, in fact, the intent of the law.[5] Information on the effect of these standards, and different approaches taken by States, should be useful to all States as they develop new regulatory programs.

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[3] The Department of Health and Human Services has published and made widely available a pamphlet entitled "Guide to Health Insurance for People with Medicare," including a revised 1980 version. The pamphlet was jointly developed by the Department and the National Association of Insurance Commissioners, and is available in all Social Security district offices and from the Health Care Financing Administration. Department of Health and Human Services, pub. No. HCFA–02110. A number of States have also developed their own versions of this pamphlet for agent use within that State.

[4] Proposed rule. "Medi-gap—Certification of Medicare Supplemental Health Insurance Policies," Federal Register, vol. 46. No. 13. Jan. 21. 1981. p. 6296.

[5] See conference report on legislation. "Social Security Disability Amendments of 1980," House report No. 96–944. and remarks in the Senate of Senators Chiles, Baucus, Domenici, Bradley, Metzenbaum, Congressional Record, Jan. 30, 1980, pp. 633–642.

II. FTC POWERS LIMITED BY CONGRESS

Legislation to reauthorize the operations of the Federal Trade Commission (FTC) proved to be controversial, as Congress moved to restrict the agency's rulemaking powers. Objections were registered against a number of rulemaking proceedings which have been of particular interest to elderly consumers—including insurance sales practices and longstanding efforts to define unfair selling practices in the funeral industry.

Public Law 96–252, effective May 28, 1980, contained the following amendments of significance to the elderly:

Changes to funeral industry rule: The FTC may now issue final rules governing sales practices within the funeral industry, but the final rule must be limited to mandating price disclosures, banning deceptive or coercive practices, and prohibiting unlawful practices such as boycotts or threats.

The earlier version of the reauthorization bill approved by the House of Representatives (H.R. 2313, passed by the House on November 27, 1979) would have restricted the FTC from issuing any rules governing the funeral industry. The FTC had documented a wide range of abuses within the funeral industry during a period of 4 years, and a staff report issued in 1978 with proposals for prohibiting questionable sales practices and requiring item by item price disclosures met with strong industry opposition.[6]

The compromise reached by House and Senate conferees will allow the FTC to proceed with some aspects of the rule as originally proposed. A revised proposed rule was issued by the FTC on January 22, 1981.[7]

Prohibitions against insurance investigations: The FTC reauthorization bill also prohibits the FTC from conducting investigations into the "business of insurance" unless a specific study is requested and approved by a majority vote of either the Senate or House Commerce Committees. If the FTC is authorized to conduct any insurance study through such a request, the study activity would cease with the election of a new Congress as committee members change, unless specifically renewed by a new committee.

The House and Senate conferees made it clear, through report language, that authority to conduct studies be limited to general review and analysis of insurance policy issues, not "investigations" of the industry or segments of the industry. Report language also made clear the House and Senate conferees' intent that insurance is to be regulated by the States only.[8]

Challenges to insurance industry investigations and studies originated in the Senate version of the bill (S. 1991, passed by the Senate on February 7, 1980). During debate in the Senate, however, Senator Lawton Chiles, then-chairman of the Committee on Aging, successfully offered an amendment to exempt the FTC's ongoing study of

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[6] "Funeral Industry Practices." Final staff report to the Federal Trade Commission and proposed trade regulation rule, Bureau of Consumer Protection, Federal Trade Commission, 1978.

[7] "Funeral Industry Practices." Revised proposed rule. Federal Register, vol. 46, No. 14, Thursday, Jan. 22, 1981, p. 6976.

[8] U.S. Congress. House of Representatives. "Conference Report on Federal Trade Commission Amendments; Report To Accompany H.R. 2313." Washington, Rept. No. 96–917.

medigap insurance sales to the elderly from the blanket prohibition against insurance studies. The amendment was contained in the final version of the bill signed into law (Public Law 96–252).

Therefore, with the exception of the FTC's continued work with the Health Care Financing Administration on the medi-gap insurance study required by the new medi-gap law,[9] all activities of the FTC staff in any way related to the "business of insurance" ceased when the authorization bill was signed. The FTC had completed a study of the value of cancer insurance policies, frequently sold to the elderly and the subject of earlier critical congressional hearings,[10] but the report was never released by the Commission.

Consumer participation cutbacks: The final bill also provides that no person (or group) may receive more than $75,000 in public participation funds for any single rulemaking proceeding, or more than $50,000 in any 1 year. The total authorization for the FTC's public participation program was reduced from $1 million to $750,000 per year.

The FTC's public participation program frequently allowed elderly consumers and other advocates to participate in the development of rules of interest to them (such as the funeral industry proposed rules). The program supports transportation and lodging, for example, of low-income individuals to testify at public hearings.

Congressional oversight of proposed FTC rules: The FTC is required to provide both the House and Senate Commerce Committees with advance notice of any proposed rulemaking 30 days before publication in the Federal Register. All final rules must be submitted to both the House and the Senate, and cannot become effective until after a 90-day period of congressional review. If, within this 90-day period, both the House and Senate adopt a resolution expressing disapproval, the rule is effectively vetoed.

III. INTEREST RATE CEILINGS PHASED OUT

Ceilings on the rate of interest paid on savings deposits will be phased out as a result of legislation passed by Congress and signed into law on March 31, 1980 (Public Law 96–221).

The legislation creates a six-member Depository Institution Deregulation Committee, which has a 6-year authority to control rates paid on deposits. At the end of the 6-year phaseout period, Government financial regulations on interest rates—collectively known as "regulation Q"—will expire.

The effort to phase out interest rate ceilings was initiated by a number of consumer organizations representing the elderly—particularly the Gray Panthers—because of their effect on keeping interest ceilings for small savers very low (5.5 percent), while allowing more affluent savers higher market rates of interest.[11]

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[9] See discussion of medi-gap law above.

[10] U.S. Congress. U.S. Senate and U.S. House of Representatives. "Cancer Insurance and the Elderly." Joint hearing of Subcommittee on Antitrust, Monopoly, and Business Rights of the Senate Committee on the Judiciary and Select Committee on Aging, House of Representatives. Mar. 20, 1980. Washington, Ser. No. 96–61.

[11] See "Developments in Aging: 1979," part 1, pp. 167–169, for a full discussion of these efforts.

Chapter 9

THE WHITE HOUSE CONFERENCE ON AGING

A LOOK AT THE CONFERENCE AND BEYOND

The 1981 White House Conference on Aging is more than a continuation of conference tradition—more than a "one-time" event. The Conference will reaffirm the Nation's commitment to the elderly through a mechanism which permits both the President and the Congress to draw national attention to the quality-of-life issues confronting older Americans.

The White House Conference on Aging, however, is a one-in-a-decade social policy phenomenon which both respects and upholds the belief of citizen participation in Government and in the decisions which affect their lives. It is both a series of events and a process whereby people from across the Nation can participate in the shaping of future policy.

The impact of the Conference will be measured over time in terms of commitments made by the Nation's leaders to implement a national policy on aging and to translate the post-Conference recommendations into legislative and administrative action. Final success lies in the extent to which the spirit of citizen participation generated in thousands of local communities and in all States continues to promote discussions and resolutions of the problems and opportunities for a longer life.

On October 18, 1978, President Carter signed legislation (Public Law 95–478) authorizing the third White House Conference on Aging to be convened in 1981. Authority to plan and conduct the Conference was delegated to the Secretary of the Department of Health and Human Services (HHS) and the Executive Director of the Conference. The White House Conference on Aging is scheduled to take place in Washington, D.C., from November 29 to December 3, 1981.

President Carter, explaining the need for the 1981 White House Conference on Aging at a reception held for the Advisory Committee at the White House on March 26, 1980, stated:

> Every day in our great country about 5,000 Americans reach the age of 65. And this is a very important time in their lives. It's a time either of increased choices in their life or a narrow restraint on their life. It's a time for the prospect of warm relationships with their families or their friends; it's a time of security and anticipation of a future that's stable, that will meet their needs, or it's a time of uncertainty and insecurity, and perhaps fear. It's a time of confidence about the coming days or it's a time of pessimism about their future life. This question, how Americans approach their 65th year and how they live their lives after the age of 65, will be the subject of the White House Conference on Aging.

I. HISTORICAL BACKGROUND

A. Legislative Mandate

The authorizing legislation for the 1981 White House Conference on Aging (Public Law 95–478) sets forth several pre- and post-planning requirements including:

—Providing Federal financial assistance to State and area agencies to help them hold local and State conferences prior to the White House Conference.

—Appointing and supporting an advisory committee for the Conference and such technical committees as may be needed to insure the success of the Conference.

—Conducting the Conference in such a way that the broad participation of older persons, including low-income and minority older persons, is assured; and

—Issuing a final report to the President and Congress, within 6 months of the conclusion of the Conference, which shall include a statement of, and recommendations for, implementation of a comprehensive, coherent national policy on aging, (HHS Secretary will submit recommendations for legislative and administrative action within 90 days after submission of the final Conference report).

The Secretary of HHS is mandated under the authorizing legislation to insure that current and adequate statistical data and other information on the well-being of older individuals in the United States is readily available to Conference participants in advance. In fulfillment of this Conference requirement, the Secretary may award grants to, or enter into contracts with, public agencies and/or nonprofit private organizations

B. Past White House Conferences on Aging

The White House Conference on Aging has a significant history evolving from an Executive order issued by President Truman in August 1950. Under the vested authority of the President, the Federal Security Agency (predecessor to the Department of Health and Human Services) invited 816 Americans to collectively discuss the issues of concern to its older population. This national meeting established a precedent for convening White House Conferences on Aging in the decades to follow.

Prompted by greater awareness and heightened social concern regarding an expanding older population, President Dwight Eisenhower signed legislation authorizing the first White House Conference on Aging to be convened in 1961. Foremost, the 1961 White House Conference on Aging included the participation of 2,500 delegates from across the country and served as the precursor to a number of significant legislative developments including the Older Americans Act of 1965; medicare; the National Housing Act Amendments; and the creation of a Subcommittee on Aging in the Senate, followed by the establishment of the Senate Special Committee on Aging.

Ten years later, the 1971 White House Conference on Aging charted an expanded administration and legislative course which resulted in the enactment of 77 percent of the Conference's most significant recom-

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mendations. Appearing before the final session of the 1971 Conference, President Richard Nixon pledged to support a fivefold increase in the AoA budget over his original budget request; a $100-million nutrition bill for the aging, the upgrading of nursing homes, and private pension reforms. Within 2 years, all of these commitments were translated into Federal legislation.

C. Conference Leadership

The initial planning of the 1981 Conference, begun in June 1979, was conducted under the direction of the Secretary of HHS and in conjunction with the Commissioner on Aging and the Director of the National Institute on Aging. In December 1979, former Congressman Jerome Waldie of California was appointed by HHS Secretary Harris to begin Conference planning activities and serve as its Executive Director. Shortly thereafter, Leon Harper of California was named to the position of Associate Executive Director.

The first major preconference activity was President Carter's December 1979, announcement naming the six key individuals who will spearhead the 1981 National Conference. Sadie T. M. Alexander, an 82-year-old attorney from Philadelphia (the first black woman in the United States to receive a Ph. D.), was named chairperson of the 1981 White House Conference on Aging. At the swearing-in ceremony convened at the White House, President Carter also appointed four deputy chairpersons: Dr. Arthur S. Flemming, former U.S. Commissioner on Aging and chairman of the 1971 Conference; Dr. Bernice Neugarten, psychology professor and gerontologist, Chicago, Ill.; Mrs. Lupe Morales, a community activist for Hispanics, Los Angeles, Calif.; and Dr. Ellen Winston, home health services advocate and former U.S. Commissioner on Welfare, Raleigh, N.C.

On March 21, 1980, HHS Secretary Harris released the names of a 55-member Advisory Committee for the 1981 White House Conference on Aging. Pursuant to the mandates of the authorizing legislation, the committee includes representation from the Federal Council on Aging, public and private nonprofit organizations, and individuals who work on behalf of the aged. The Advisory Committee's task is to assist and participate in the planning, convening, and reviewing of the Conference activities as directed by the White House Conference chairpersons.

II. 1980—A YEAR OF PREPARATION

The convening of the 1981 White House Conference on Aging will have been preceded by 19 months of preconference planning activities and events. These activities have been designed to insure a broad cross-section of citizen participation and to facilitate a thorough examination and development of issues for consideration at the national meeting.

Conference officials established two principal sources of issue development analysis and evaluation intended to insure that national attention to special aging issues is guaranteed—issues affecting particu-

lar populations or Federal policies and programs which would not be treated in depth through the local community or statewide citizen forum process. They are:

—40 special concerns and problem-oriented miniconferences (reports due to the Conference office by February 15, 1981.

—16 technical committees, each focusing on an issue area (reports due February 1, 1981.

A. Miniconferences

The White House miniconferences, conducted between September 1980 and January 1981, provided a structure for the development of special issue areas, such as housing, vision, long-term care, and minority elderly, for consideration by Conference delegates in advance of the national meeting.

The miniconferences were organized and sponsored by a host of convenor organizations interested in exploring selected aging issues. Nearly 40 such miniconferences have been officially recognized and approved by the 1981 White House Conference on Aging and include the following subject areas:

—Black elderly.
—Hispanic elderly.
—American Indian elderly.
—Urban elderly.
—Rural elderly.
—Women.
—Spiritual well-being.
—Corporate sector.
—Transportation.
—Mental health.
—Lifelong learning.
—Energy.
—Art and humanities.
—Low vision.
—Foot care.
—Intergenerational.
—Voluntary sector.
—Euro-American elderly.
—Recreation and leisure.
—Pacific/Asian elderly.
—Media.
—Foundations.
—Dental health.
—Elderly poor.
—Hearing impaired elderly.
—Legal barriers.
—Long-term care.
—Savings.
—Alcoholism.
—Nonservices.
—Senior centers.
—Self-help and senior advocacy.
—Consumer problems.
—Legal services.
—Patients rights.
—National health insurance.
—Older veterans.
—Alzheimer's disease.
—Environmental issues.
—Housing.

An estimated $1.1 million has been provided by various Federal agencies, such as the Administration on Aging, the Social Security Administration, and the Community Services Administration, to support miniconference activities. Financial contributions from private funding sources have also been utilized in support of this issue development process.

The summarized reports and recommendations emanating from the miniconferences were to be submitted to the Conference office by February 15, 1981, for distribution to State conference delegates for their review and consideration.

B. Technical Committees

On August 5, 1980, Executive Director Waldie announced that Secretary Harris had appointed 135 individuals to serve on 16 issue-oriented White House Conference Technical Committees and stated:

> Through the assistance of the technical committees, delegates to the 1981 meeting will be well-prepared for educated decisionmaking, leading to a comprehensive and coherent national aging policy.

Total membership on the technical committees is composed of 50 advisory committee members in addition to the recent appointments of 85 citizens from throughout the country. Together, this group brings both professional and lay expertise to the committees in such fields as gerontology, economics, law, medicine, long-term care, minority affairs, private industry, labor, education, and religion.

The technical committees are charged with the responsibility of preparing background materials for delegates to the 1981 Conference. Foremost, the technical committees are expected to reach consensus in defining major issues for consideration at the national meeting. The 16 technical committees include:

—Retirement Income.
—Health Services.
—Health Maintenance.
—Long-Term Care.
—Family, Social Services, and Other Support Systems.
—Physical and Social Environment and the Quality of Life.
—Older Americans as a Growing Resource.
—Employment.
—Creating an Age-Integrated Society Within:
    Societal Institutions.
    The Economy.
    The Educational System.
    Religious Institutions.
    The Family.
    The Media.
    The Governmental Structure.
—Research.

C. Nationwide Citizen Forums: Setting the Stage

Consistent with the preconference planning activities occurring at the national level, a comparable number of events are scheduled in thousands of communities throughout the country in preparation for the national Conference. The Conference structure provides for organized events, such as local forums, State conferences, and regional hearings, to serve as vehicles for insuring the broadest citizen participation in the discussion of aging issues and in the formulation of recommendations for the 1981 White House Conference on Aging.

1. COMMUNITY FORUMS

Thousands of community forums were conducted nationwide during May and June 1980, sponsored by area agencies on aging and other

interested organizations, to begin preparation for the national Conference. Information emanating from these local community forums articulated issues of dominant concern to citizens and was elevated to the State level for further discussion.

2. STATE CONFERENCES

Organized by State coordinators appointed by each Governor, State conferences on aging have been held or will be held in each of the States and U.S. Territories prior to June 1981. The State conferences are intended to permit public debate of quality-of-life issues concerning the elderly, to assimilate the views of citizens, and to translate these concerns into formal recommendations, based on consensus, which will be forwarded to the conference's leadership officials prior to the national meeting.

State conferences on aging are intended to serve as the forum for the selection of delegates to the national Conference. These conferences are financially supported by the Administration on Aging in the form of special grants to the States.

3. DELEGATION SELECTION

The White House Conference on Aging will convene on November 30, 1981, with 2,000 voting delegates. Travel and daily expenses will be provided for these voting delegates. An additional 2,000 Conference observers will be granted the opportunity of Conference participation which does not include voting privileges or travel cost reimbursements.

As a result of budget constraints, the 1981 Conference determined that the total number of voting delegates would not exceed 2,000, in striking comparison to the 3,500 delegates who attended the 1971 White House Conference on Aging or the 2,500 delegates participating in the first national Conference in 1961.

The selection of delegates adhered to the Conference's enabling legislation, and has been administered according to the following guidelines:

—1,000 delegates, divided among the 57 States and territories according to the proportion of the age 55 and older population of each of these jurisdictions. No State shall have less than six delegates. At least half of each State's delegation shall be female, and minority groups shall be represented in each delegation in the approximate proportion that such groups are found in the population of their respective States.

—539 delegates, one each to be chosen by the Members of Congress who were in office on February 1, 1981.

—Approximately 150 delegates granted such status because they are currently members of the 16 Conference technical committees, or are official coordinators appointed by the Governors in connection with preparations for their State conferences and the national Conference.

—The balance of delegates are to be named by the Executive Director of the Conference in the early summer of 1981, to assure that the racial, sex, age, and rural/urban profile of the overall

delegate body closely parallels that of the Nation. Also, national organizations concerned with the aged and other groups will be asked to nominate some members of this last group.

Governors and Members of Congress were asked to initiate their respective delegate selection process by February 1, 1981. Numerous legislative officials have responded and the process of documenting delegates is well underway.

D. Conference Budget

Activities generated on behalf of the 1981 White House Conference were initially funded by a $3-million appropriation under the 1979 Supplemental Appropriation Act (Public Law 96–38). Although the Conference will not be conducted until late 1981, HHS estimated that at least 2½ years were needed for planning and preconference activities. As a result, funds from the initial appropriation were to remain available until expended.

The administration's fiscal year 1981 budget requested an additional $3 million for the WHCOA, which would bring the Conference appropriations to a total of $6 million. Since the fiscal year 1981 appropriation bills for most Federal agencies and programs were pending in mid-October, a continuing resolution to guarantee Federal funding was necessary. The second or further continuing resolution (Public Law 96–536) signed by President Carter on December 16, 1980, provided funding authority for the additional $3 million for 1981. This provision of the further continuing resolution was the result of action by Senator Chiles during Senate Appropriations Committee deliberations on the Labor and HHS appropriations.

Additional funding sources for the Conference include the Administration on Aging and the National Institute on Aging which made substantial financial contributions to the Conference. Other Federal agencies and national public and private organizations have assisted the 1981 Conference by way of partial funding of the miniconferences.

Chapter 10

ISSUES OF EMERGING AND CONTINUING CONCERN

I. LIFELONG LEARNING: EDUCATION FOR OLDER AMERICANS

The 1980 session of the 96th Congress enacted legislation to increase educational opportunities for those adults who have not been able fully to benefit from existing programs. Education outreach programs, in title I of the Higher Education Act, represent a stronger initiative for continuing education programs which address the needs of underserved adults, including the elderly, women entering or reentering the work force, the handicapped, the economically disadvantaged, and individuals whose previous educational experience has acted as a barrier to lifelong learning.

Other amendments to the Higher Education Act adopted by Congress addressed the need for research on the educational interests and requirements of older adults, as well as the need for more reliable data on older Americans' participation in federally supported education programs. Changes in student financial aid programs, such as allowing less than halftime students to qualify, alleviate some of the barriers adults face in obtaining grant and loan assistance.

In preparation for the 1981 White House Conference on Aging, a miniconference entitled "Lifelong Learning for Self-Sufficiency" was sponsored by the Institute of Lifetime Learning of the NRTA–AARP, the Adult Education Association's Commission on Education for Aging, the Association for Gerontology in Higher Education, and the Population Resource Center.

The U.S. Department of Education was established. The agency's motto, "Learning Never Ends," symbolizes efforts by organizations representing the elderly to insure that older Americans derive maximum benefits from Federal education programs. One focus of these efforts was to have a policy-level individual in the Department be responsible for coordinating programs in which the elderly can participate.

A. The Higher Education Act Reauthorization

1. REVITALIZING TITLE I, CONTINUING EDUCATION

Making federally supported postsecondary programs more responsive to the increasing numbers of nontraditional students seeking educational opportunities was one of the key issues facing the 96th Congress in the reauthorization of the Higher Education Act.

> The typical student is no longer young, no longer full time, no longer just out of high school, no longer a stranger to the world of work, no longer necessarily seeking either a set of skills, or an educational credential. And to be certain, he is no longer overwhelmingly "he." [1]

A number of factors have interacted to make the elderly an important force in the population of nontraditional students. Americans are living longer and enjoying better health in old age. Our society is "graying." As the baby boom matures, the demography is shifting from one dominated by the young to one in which adults and older persons represent a growing percentage. There is a trend toward early retirement, giving millions of Americans more years of creative "leisure." At the same time, increasing numbers of older persons are facing economic and psychological pressures either to postpone retirement or reenter the work force. Finally, the demands and complexities of our highly technological society and rapidly changing social structure are replacing the concept that one gains a set of skills in youth to last a lifetime with the idea that learning is a lifelong occupation.[2]

The House of Representatives passed legislation to authorize the Higher Education Act in 1979. The bill (H.R. 5192) contained provisions for focusing and revitalizing title I. Renamed education outreach, the House-passed version of title I targeted the program on the most severely underserved adults—those whose age, race, sex, handicap, national origin, rural isolation, poverty, or previous educational experience has acted as a barrier to their participating in education programs. Rather than relying solely on the Federal Government, the House sought to attract a wide range of resources—from business and industry, labor, public and private organizations serving adults and the elderly, State and local governments—to build a well-planned system of continuing education programs.[3]

The Senate retained the goals and purposes the House had envisioned for education outreach programs in title I, part B, State Planning and Continuing Education, in its reauthorization of the Higher Education Act, S. 1839 (S. Rept. 96–733). However, the Senate Labor and Human Resources Committee added two new sections to the title. A Commission on National Development in Postsecondary Education (part A) was authorized to study institutional changes necessary to respond to new economic and demographic trends. A three-part program of institutional adaptation and innovation (part C) was established to encourage institutions to update curriculae, serve women reentering the work force, and help disadvantaged youth make the transition to postsecondary education. The Senate passed S. 1839 on June 23, 1980.

Senate and House conferees, assigned to work out the differences between the House and Senate versions of the Higher Education Act reauthorization, refocused title I on lifelong learning and continuing

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[1] U.S. Congress. House of Representatives. Subcommittee on Postsecondary Education of the Committee on Education and Labor. "Reauthorization of the Higher Education Act and Related Measures." Hearings, 96th Congress, 1st session, part 2—Lifelong Learning, June 21, 1979, Washington, U.S. Government Printing Office, 1979, p. 120. (Opening statement of Representative William D. Ford, chairman.)

[2] For a detailed discussion of the educational needs and participation patterns of older Americans, see "Developments in Aging: 1979," part 1, pp. 215–218.

[3] Additional information on the purposes and provisions of the House version of title I may be found in "Developments in Aging: 1979," part 1, pp. 218–220.

education for underserved adults (Conf. Rept. 96–1337). As signed by the President on October 3, 1980, Public Law 96–374 retained parts A and B of title I, providing for a Commission on National Development in Postsecondary Education, and education outreach programs.

The provisions for education outreach programs in title I–B center on State planning and programs to promote coordinated delivery systems of adult education opportunities. Ninety percent of the funds authorized for part B of title I are allocated to the States—60 percent of the allocation on the basis of relative adult population and 40 percent divided equally among the States (section 112). States must use between 15 and 20 percent of their allocation for comprehensive statewide planning (section 113). These planning provisions supplant and incorporate the State Postsecondary Education Commissions and planning activities which were authorized previously by title XII of the Higher Education Act (sections 1202 and 1203). Educational information centers, formerly authorized by title IV–A, subpart 5 (sections 418 A and B) of the Higher Education Act, are also transferred to the education outreach programs (section 114). Thus, the new title I–B brings under one program, State planning, information, and grant activities for continuing education, and eliminates duplicate reporting and submission of State plans.

The remainder of funds allocated to the States may be used to make grants and enter contracts with public and private organizations, higher education institutions, business, industry, and labor for programs to promote access to postsecondary education for adults who have been inadequately served (section 115). Such programs include a number of initiatives beneficial to older Americans, including:

—Legal, vocational, and health educational services and informamation for older individuals who use preretirement education as a means to adjust to retirement.

—Educational and occupational information and counseling services to aid adult women in entering or reentering the work force.

—Community education services for adults in rural areas.

—Postsecondary education programs for individuals who have been inadequately served, especially the handicapped, older persons, part-time students, migrants, and others who would be unlikely to continue their education beyond high school.

—The removal of barriers to continuing education caused by rural isolation and other rural-related factors.

Ten percent of the funds appropriated for title I–B are reserved for Federal discretionary grants (section 116). These grants may be used to develop innovative delivery systems to improve adults access to postsecondary education, expand the range of educational and community resources to meet the needs of underserved adults, promote telecommunications and other types of interstate delivery systems, develop statewide, regional, and national programs to coordinate educational and occupational information, and provide technical assistance to the States for their planning and program activities.

Title I–B also continues the authorization for the National Advisory Council on Continuing Education (section 117).

Congress is authorized to appropriate up to $20 million for education outreach programs for fiscal year 1981. The authorization level increases by $10 million per year, to $60 million for fiscal year 1985.

2. EDUCATIONAL DATA AND RESEARCH

When the Higher Education Act came before the Senate on June 23, 1980, Senator Lawton Chiles offered a series of amendments to promote research by the National Institute of Education (NIE) on the needs of nontraditional students, to make data on participation by older adults more readily available, and to authorize the Secretary of Education to study the remaining barriers faced by nontraditional students in pursuing educational opportunities. The amendments were adopted unanimously by the Senate and resulted in the following changes in the general education provisions:

—Included age, in the statement of purpose of the NIE as one of the criteria for insuring equal educational opportunity.

—Established, as one of the research and demonstration efforts of the NIE, the study of the special problems facing nontraditional students, including older and part-time students.

—Required annual evaluation reports of the Department of Education to tabulate data on the effectiveness of educational programs by age, when such data is available.

—Authorized the Secretary of Education to study any additional barriers to adult postsecondary education faced by nontraditional students.

The amendments were retained in the House/Senate Conference on the Higher Education Act Reauthorization. Since both House and Senate bills provided for a number of studies of postsecondary education and student financial aid, the conferees assigned the authority to study the barriers to postsecondary education faced by nontraditional students to the Commission on National Development in Postsecondary Education, title I–A.

3. INCREASING ACCESS THROUGH STUDENT FINANCIAL AID

Changes in the student financial aid provisions of the Higher Education Act, title IV, are designed to increase access to postsecondary education for adults and may prove beneficial to older Americans. Title IV–A authorizes higher education institutions to award up to 10 percent of their supplemental educational opportunity grants (SEOG's) to less-than-half-time undergraduate students (section 413C(c)). The previous requirement that students be enrolled on at least a half-time basis to qualify for SEOG's was regarded as a barrier to working adults, homemakers, and older persons who wish to continue their education.

Title IV–F, the general provisions relating to student assistance, was also amended by the Higher Education Act reauthorization to exclude home equity and an asset reserve of $10,000 (or $50,000 if net assets include a farm or business) from consideration of need for Federal student financial aid (section 482(b)(5)). Many working and retired adults have equity in their homes and an asset reserve which has precluded them from obtaining educational grants and loans, although their effective income is too small to cover continuing education expenses.

B. Establishment of the Department of Education

May 4–9, 1980, marked the official opening of the U.S. Department of Education. Authorized by Public Law 96–88, the new Department chose as its motto, "Learning Never Ends," which underscores the importance of education as a lifetime pursuit. The opportunity for greater attention to the needs of nontraditional students provided by the creation of a separate Cabinet-level agency to administer the bulk of Federal education programs was viewed with optimism by organizations representing older Americans and adult learners.

While there are virtually no education programs authorized solely to benefit individuals aged 60 and over, almost every office of the new Department administers programs in which the elderly can participate and from which they can benefit. For example, the Office of Vocational and Adult Education directs the adult education program, which is designed to help educationally disadvantaged adults of all ages gain the basic knowledge and skills they need in an increasingly complex society. The Office of Postsecondary Education oversees programs authorized by the Higher Education Act, including title I continuing education programs and the fund for improvement of postsecondary education, which supports such activities as Elderhostel. In addition, the National Institute of Education and other parts of the Department administer a wide range of programs and support research and demonstrations which affect older Americans, including library services, career education, the community schools program, and bilingual education.

On December 13, 1979, Senator Chiles wrote the first Secretary of Education, Shirley M. Hufstedler, to request that an individual at the policy level be appointed to be responsible for and coordinate education programs benefiting older persons. In her formal response and at subsequent hearings of the Senate Subcommittee on Labor-HHS, Education Appropriations, the Secretary indicated her personal interest in seeing that the many programs of the Department meet the educational needs of the elderly, as well as enumerating the research and demonstration efforts the agency would undertake to better serve older Americans.

One of the task forces assigned to review special educational needs and make policy recommendations to the Secretary was to be devoted to the older learner. The Secretary subsequently appointed an individual to the Office of Planning and Budget to compile information for the task force on the programs in which older persons can participate, their degree of participation, and how these programs are meeting their needs. This review process was initiated in late 1980, but its continuation will be contingent upon the interest of the Secretary under the new administration.

C. Appropriations

Educational programs for older Americans faced the same limitations of a tight budget for fiscal year 1981 as did education programs in general. Below are listed the appropriations for programs which are of particular importance to the elderly, with comparisons between funding for fiscal year 1980 and 1981:

[In millions of dollars]

	1980	1981
Public libraries (services and interlibrary cooperation)	67.5	74.5
Adult education (grants to States)	100.0	120.0
Education information centers (now under title I, HEA)	3.0	3.0
State postsecondary education commissions (now under title I, HEA)	3.0	3.0
University community services and continuing education (now continuing education program and planning under title I, HEA)	9.0	9.
Fund for improvement of postsecondary education	13.5	13.
Community schools	3.1	10.
Consumers education	3.6	3.
Career education	15.0	15.

Adult education, programs of interlibrary cooperation, and community schools enjoyed increases in fiscal year 1981, while other education programs identified as potentially beneficial to older persons managed to hold their own. The final appropriation levels, however, do not reflect the fact that some of these programs—notably the continuing education planning and information services now authorized under title I and career education—were targeted for zero funding or significant cuts in the 1981 Budget and recision requests by the Carter administration. As pressure for spending cuts increases, it seems likely that the Reagan administration may also propose austere budgets for these programs.

D. White House Miniconference on Aging Education

"Lifelong Learning for Self-Sufficiency" was the theme of the miniconference endorsed by the White House Conference on Aging held in Racine, Wis., on November 12–14, 1980. The miniconference was supported by funds from the Administration on Aging and was cosponsored by the Institute of Lifetime Learning of the NRTA–AARP, the Adult Education Association's Commission on Education for Aging, the Association for Gerontology in Higher Education, and the Population Resource Center.

The miniconference recommendations focused on four areas of self-sufficiency for the elderly in which education plays a vital role:

—Surviving, learning for economic sufficiency.
—Coping, learning for practical life skills.
—Giving, learning for community contribution; and
—Growing, learning to become a fuller human being.

Nine strategies were developed by the conference work groups to strengthen lifelong learning for self-sufficiency among older Americans. These include:

—Empowering older Americans themselves to obtain better responsiveness from institutions, and to meet their own needs, wherever possible.
—Using existing institutions, programs, and resources to provide needed services and support, wherever possible.
—Providing information, counseling and support services.
—Changing negative laws, policies, regulations, or practices.
—Beginning earlier, at midlife or sooner, to prepare individuals for competent and constructive aging.

—Targeting some programs to meet the needs of the disadvantaged.
—Increasing public understanding of the problems and potentialities of older people.
—Conducting relevant research; and
—Alleviating economic barriers to learning for self-sufficiency.

Using these strategies, the delegates to the miniconference pursued the prospects of educational opportunities for older Americans in terms of the four areas of self-sufficiency. Discussion centered on how the public and private sectors can be encouraged to promote work and volunteer opportunities for the elderly, how older persons can be mobilized for service as a vast human resource, and how their coping and life skills can be increased for a lifetime of satisfying competency and productivity.

The recommendations of the miniconference were submitted to the Technical Committee on Education of the White House Conference on Aging, which will issue materials and a report for the use of the delegates to the White House Conference.

E. Outlook for 1981

The 1981 White House Conference on Aging, and the emphasis education is given in the Conference recommendations, will be an important indicator of how education for older adults will fare in the 1980's. Rather than have a separate consideration of education at the Conference, as was done at the 1971 White House Conference on Aging, the 1981 Conference will incorporate education in each of the major topics of discussion.

The 1981–82 sessions of the 97th Congress will be taking up the reauthorization of one of our major education programs—the Vocational Education Act. Early in the summer of 1980, the Department of Education developed major policy recommendations for the reauthorization, and some attention was devoted to the implications of the program for older workers, since the act's provisions are aimed at individuals up to age 65. The new administration's plans and proposals for vocational education are uncertain, but the House Education and Labor Committee began oversight hearings in the fall of 1980. The Senate Labor and Human Resources Committee was planning to begin hearings on vocational programs early in 1981. As emphasis on expanding work opportunities for older Americans grows, exploring the ways federally supported vocational education programs can benefit older persons gains importance.

1981 also marks the reauthorization of the Older Americans Act. Many education programs for the elderly are sponsored by senior centers, nutrition sites, and area agencies on aging (AAA's). Organizations representing the elderly and congressional committees are expected to review the impact of these education services on older Americans and particularly how efforts by educational institutions, public, and private organizations can be better integrated to provide older persons the learning opportunities they seek.

The new administration is expected to review the status of the Department of Education with possible changes in mind. These might include reduction of the Cabinet-level Department to a subcabinet

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agency, similar to the National Aeronautics and Space Administration, or placing Federal education programs within another Department, such as the Department of Labor. Any change in the status of the Department of Education, however, will require congressional authorization.

II. ELDER ABUSE

A. Joint Committee Hearing

On June 11, 1980, the Senate Special Committee on Aging and the House Select Committee on Aging conducted a joint hearing on "Elder Abuse."

The hearing was conducted largely in response to a number of recent studies and reports documenting the physical, psychological, and financial abuse of older people by members of their own families. The major findings of these studies and reports are summarized later in this section.

During the hearing, cochaired by Senator David Pryor of Arkansas and Representative Claude Pepper of Florida, testimony was taken from elderly victims of abuse and experts on the subject.

A typical account of the abuse suffered by many of the victims came from a 79-year-old Massachusetts woman who told the committee about the abuse she experienced from her daughter:

> Several times she locked me out of the house. One of those times it was very cold and snowing with ice on the ground. I had to get to a pay station to call a friend to come and get me. My daughter's treatment of me kept getting worse. Always hurting me physically and mentally; kicking me, pushing me, grappling with me, telling me to get out, at one time throwing a drawer down the stairs at me, calling me names, telling me I belonged in a nursing home and why didn't I go to one. I was not included in family festivities for any of the holidays. She told me I was senile and paranoid and my brain was all shriveled up.[4]

The overwhelming difficulty of combating elder abuse was described by Dean John J. Regan of Hofstra Law School:

> Dealing with the problem of the abused elder presents a classic case of an age-old tension: How to reconcile society's desire to protect its vulnerable citizens while at the same time respecting their civil rights, particularly their rights to liberty, privacy, and autonomy. At stake here are, on the one hand, the State's right as paren patriae to intervene, and, on the other hand, the individual's right to give informed consent to the receipt of social and medical services. Proposed legislative solutions must likewise give attention to the developing constitutional principle that involuntary intervention by government in the lives of its citizens be as little restrictive of liberty as is consistent with legitimate legislative goals and the welfare of the individual.[5]

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[4] U.S. Congress. Senate and House. Senate Special Committee on Aging and House Select Committee on Aging, joint hearing on "Elder Abuse," June 11, 1980, Washington, D.C., pp. 17–18.

[5] Ibid., p. 56.

As a part of its preparation for the joint hearing on "Elder Abuse" which was held with the House Select Committee on Aging, the Senate Special Committee on Aging prepared a summary of the findings of several studies and reports regarding elder abuse and its causes. These findings were published in the hearing record of June 11, 1980, and are reproduced below.

In addition, the Senate Special Committee on Aging conducted a survey to determine how many States have adopted adult protective services laws as a means of coping with elder abuse. The results of the survey, which also explored a number of other issues related to elder abuse, are also included in the following section.

B. ELDER ABUSE: AN OVERVIEW

I. Nature of the Abuse

LACK OF INFORMATION

There are no statistics to document the scope of parental abuse by adult children, however, findings of a recent report conducted by the University of Maryland tend to suggest that elder abuse occurs less frequently than spouse abuse but as frequently as child abuse (600,000 cases a year on the average). After completing a 1979 study on elder abuse, Dr. Richard Douglas with the University of Michigan Institute on Gerontology concluded that maltreatment of the elderly is a real and complex problem about which too little is known and too little is being done.

MOST ABUSE IS DONE BY RELATIVES

Abusers are most often relatives of the abused. (Block, Marilyn R. and Sinnot, Jan D., "The Battered Elder Syndrome," College Park, Md., University of Maryland Center on Aging, November 1979.)

MOST VICTIMS ARE WOMEN

In general, the abused elder appears to be severely disabled, older than average (75+), middle-class woman who is psychologically abused by her own relatives in spite of attempts to end the abuse by seeking help through normal channels. Anecdotal accounts suggest that the abused felt trapped in their situation. (Block, Marilyn R., "The Battered Elder," page 80.)

ELDER ABUSE: A RECURRING EVENT

A study undertaken in Massachusetts by Legal Research and Services for the Elderly found that elder abuse is a recurring event—70 percent of the surveys returned to those conducting the study indicated that abuse occurred more than twice. Further, 40 percent of the victims often received visible injuries. (Berman, James, et al., "Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals," Legal Research and Services for the Elderly, June 1, 1979.)

ELDER ABUSE LIKELY TO INCREASE

Situations where an older person is abused by family members are likely to increase as greater numbers of parents age and require care from their children. Decreasing fertility and mortality rates mean that there will be more older persons and fewer children available as possible caretakers. The adult child may be faced with as many as two sets of grandparents to care for, as well as aging parents. Further, increased divorce rates increase the likelihood that the caregiver will be providing the care without the financial or other assistance of a spouse. (Block, Marilyn R., "The Battered Elder," page 93.)

THREE ASPECTS OF ABUSE/NEGLECT: PHYSICAL, PSYCHOLOGICAL, AND FINANCIAL

The aforementioned Massachusetts study concluded that in 75 percent of the abuse cases cited, the abuser lived with the elderly person who was victimized. The abuser was a relative of the elderly victim in 84 percent of the citings. Other abusers may include staff or operators of foster homes, nursing homes, mental hospitals, etc. In other cases, mental or physical deterioration may result in older persons being unable to care for themselves on a day-to-day-basis. Hence the abuse under discussion here, may be inflicted by: relatives, paid caretakers, or the individuals themselves.

The kinds of abuse or neglect identified by researchers can be categorized as: physical, psychological, or financial/legal (misuse of assets, etc.).

Findings vary as the most frequent kind of abuse. While the University of Maryland study found that psychological abuse occurred most frequently, a study conducted by Elizabeth Lau at the Chronic Illness Center in Cleveland, Ohio, found that physical abuse was the most frequent. Lau found that almost

three-fourths of the abuse studied involved physical abuse and over half involved psychological abuse. Further, the elderly clients in the study generally suffered from more than one kind of abuse.

ELDER ABUSE JUST ONE COMPONENT OF FAMILY VIOLENCE

While information about elderly abuse is only now becoming available, recent studies on child abuse and spouse abuse indicate that abuse of the elderly is only one component of a larger problem; family violence. One expert on the subject has written that: "* * * the family is by far the most physically violent group or institution, except for the police or military at war." (Dr. Murray Straus, quoted in Jones, Jean Yarvis and Fowler, Jan., "Child Abuse: History, Legislation, and Issues," Congressional Research Services, Library of Congress, Washington, D.C., December 19, 1979, page 26.)

PROTECTIVE SERVICES: A TWO-HEADED CREATURE—PART SANTA CLAUS AND PART OGRE

In some instances, a mentally or physically infirm elderly person, who may fear the social worker or reprisals from a caretaker, refuses to accept essential medical, social, or other services. Since, unlike a child, an adult is competent until adjudicated otherwise, such a refusal may result in the need for legal intervention in order to authorize necessary protective services. This legal intervention could include guardianship, conservatorship (guardian of property), power of attorney, protective placement, or court-ordered services. This intervention also raises vital questions as to how much control society should exert over personal liberties:

> On the one hand are the ideals of personal choice, individual freedom, the respect for individual freedom, and the respect for individual differences. On the other are the principles that society has a duty to protect those unable to care for themselves and to protect itself from dangerous and destructive situations. (Regan, J. J. and Springer, C., "Protective Services for the Elderly." U.S. Senate, Special Committee on Aging, "Protective Services for the Elderly: A Working Paper," Washington, D.C.: GPO, 1977, page 12.)

Not only do some victims refuse to acknowledge the problem, but many professionals who want to intervene cite a lack of legal protection for themselves and for victims, as well as a lack of shelters, funding services, and other resources.

STUDY STRESSES THE NEED FOR LAW

A 1977 report prepared by Prof. John J. Regan, then with University of Maryland Law School, and Georgia Springer, staff attorney, Legal Research and Services for the Elderly, National Council of Senior Citizens, cited the "* * * glaring need for reform of State laws concerning civil commitment, guardianship, and protective services." (Regan, J. J., "Protective Services for the Elderly," page 13.) It may be that the failure of States to reform laws (or to even address the problem at all) stems from circumstances similar to those encountered by the advocates of child abuse legislation: A reluctance to admit that the problems exist:

> Ironically, it may very well be the abhorrence of child abuse which has made it such a slow-moving area of both Federal and State legislation. The very idea that a parent, who is supposed to love and protect his offspring, could be responsible for his or her child's injury, or even death, is so repulsive that many are reluctant to believe it. (Jones, Jean Yavis and Flower, Jan, "Child Abuse," page 1.)

II. Causes of Elder Abuse

STUDIES STRESS NEED FOR COMMUNITY-BASED SUPPORT SERVICES

Burston (1975) views battering of the elderly as a natural consequence of inadequate services to families who need support for caring for older family members. (Block, Marilyn R. and Sinnot, Jan D., "The Battered Elder Syndrome," College Park, Md., University of Maryland Center on Aging, November 1979, page 80.)

The need for community-based services was also highlighted in a recent study on guardianship funded by the Administration on Aging. The study, issued in December 1979, stated:

> The need for guardianship is clearly related to the extent and quality of protective services. Given unlimited resources, most elderly now declared in-

competent and institutionalized could be maintained in the community, particularly with the use of legal mechanisms less restrictive than guardianship (e.g., representative payee). (Schmidt, Winsor, C., et al., "Public Guardianship and the Elderly." Tallahassee, Fla., Florida State University Institute for Social Research, December 1979, page 121.)

In a similar vein, a recent Massachusetts study found that preventive strategies most often recommended by professionals and paraprofessionals surveyed included referral to social service agencies, counseling, arrangements for in-home services, and removal of the victim from the abusive situation. (Bergman, James, et al., "Elder Abuse in Massachusetts: A Survey of Professionals and Paraprofessionals," Legal Research and Services for the Elderly, page 2.)

Again, a 1977 study on protective services conducted for the Senate committee concluded that "* * * many tragedies might not occur if legal processes were geared to the task of obtaining support and services for elderly clients before they are forced from their homes." (Regan, J. J. and Springer, C., "Protective Services for the Elderly." U.S. Senate, Special Committee on Aging, "Protective Services for the Elderly: A Working Paper," Washington, D.C.: GPO, 1977.)

STRESS APPEARS TO BE CAUSE

"Like other abused dependents, elders are most often repeatedly abused by family members suffering from stress." (Block, Marilyn R., "The Battered Elder" page 80.)

ABUSIVE PERSON MAY ALSO BE OLDER AND UNDER GREAT STRESS

A study conducted in Cleveland, Ohio, found that as lifespans increase, caregivers who are themselves elderly, are more common. Community resources are generally less available to the elderly person cared for by family than to the isolated individual alone in the community. The result is often unrelenting stress of constant responsibility placed upon or accepted by a relative malequipped by personality, other responsibilities, skill, age, or financial resources, to successfully cope with the task. (Lau, Elizabeth E., "Abuse of the Elderly by Informal Care Providers: Practice and Research Issues," Chronic Illness Center, Cleveland, Ohio, November 20, 1978, page 10.)

UNEMPLOYMENT APPEARS TO BE ASSOCIATED

A major stress-producing condition within society is unemployment. This is supported by child abuse literature which indicates that nearly half of the fathers of abused children were not employed at some point during the year preceding the abusive act and 12 percent were unemployed at the actual time of the abusive act. (Block, Marily R., "The Battered Elder," page 12.)

MULTIPLE RESPONSIBILITIES

Persons who found caretaking difficult were often trying to meet the needs of their spouse and children, as well as the needs of the older relative. (Block, Marilyn R., "The Battered Elder," page 50.)

SUDDENNESS OF NEED FOR CARE

The extent of the conflict was largely dependent on whether the needs of the elder person increased slowly or rapidly. A sudden need for care is likely to cause greater tension, since the caregiver does not have an opportunity to prepare. (Block, Marilyn R., "The Battered Elder.")

AGEISM

Ageism—prejudices or negative feelings toward old age are prevalent in industrialized urbanized societies. These societies exclude the aging from continuing participation and contribution and subtly raise barriers to the availability of resources and services required:

> If we can * * * make life more fulfilling, more positive for the old so that they remain competent, companionable beings, we will certainly reduce considerably the number of elderly parents who are knocked down or verbally battered by their own exhausted children. (Block, Marilyn R., "The Battered Elder.")

PERSONALITY CONFLICTS, ROLE DEFINITIONS, AND PROBLEMS WITH COPING

Further, conflict between mothers and daughters have been discussed in terms of personality conflicts which were worsened by the passing of years and failure to redefine family roles can result in either latent hostility or possible overt violence. It has also been suggested that conflict between family members and the aged is most likely in situations where family members, either individually or as a family unit, have difficulty coping or if the parent is suffering from a chronic disease. (Block, Marilyn R., "The Battered Elder," page 11.)

ALMOST NO ONE IS IMMUNE

One researcher believes that almost no one is immune to the role of the abuser, if the discrepancy between situational demands (older person's problems, stress on caregiver) is great enough, although people vary in the degree to which they are prone to act in an abusive manner.

C. SURVEY OF STATES ON PROTECTIVE SERVICES AND OTHER ISSUES

Introduction

The Senate Special Committee on Aging in March 1980, contacted all Governors and State legislative committees on aging to obtain information on adult protective services laws and a number of related issues. The following is a list of questions contained in the letter and a statement as to why they were asked:

1. THE NUMBER OF STATE ADULT PROTECTIVE SERVICES LAWS

Question: Does your State have a protective services law or has legislation creating such a law been introduced? If an elderly person in your State will not consent to the provision of protective services, what legal authority, if any, exists for requiring the person to accept protective services or protective placement. For the purposes of this question, protective services are services furnished to an elderly infirm, incapacitated, or protected person with the person's consent or appropriate legal authority, in order to assist the person in performing the activities of daily living, and thereby maintain independent living arrangements and avoid hazardous living conditions.

Explanation: As indicated earlier in this document, recent studies indicate that elder abuse may occur as often as child abuse. The fragmented information available on the topic indicates that States are responding to the problem by enacting adult protective services laws. The first question was designed to determine which States have enacted such laws.

2. THE PORTION OF OLDER PERSONS IN STATE MENTAL HOSPITALS

Question: How many persons are residing, either voluntarily or involuntarily, in your State mental hospitals? What percent of these people are over the age of 60? What percent of these elderly people could be returned to the community if appropriate support services were available?

Explanation: Protective services workers indicate that one of the major obstacles to dealing with elder abuse is finding appropriate placement for a person who must be removed from a dangerous situation. Too often the only alternatve is some form of institutional care.

Generally, the problems faced by protective services workers and courts are not unlike those faced by families and social workers in trying to place an older person who may be experiencing mental or physical deterioration. These difficulties with placement were explained in a 1977 report prepared for the Senate Special Committee on Aging. The report, entitled "Protective Services for the Elderly," discussed placement of older persons in institutions:

> Although most communities have resources for helping the elderly with mental and physical infirmities, they have been slow to respond sufficiently to the needs. This tardiness has exacted a terrible price in human tragedy, not to mention the exorbitant economic loss to the individual and to society.
>
> The human cost is seen in the appalling condition of the victims. Neglect of the aging person leads to withdrawal, increasing disorientation, mental

disturbance, and physical deterioration. For those living in need of care, there is a constant threat of injury from fire, assault, or accident.

At the same time, the elderly who are beneficiaries of social services may be at even higher risk of injury or death. When the elderly receive that attention, this may mean that the social workers and courts will put the client in an institution where both the enjoyment and length of life are curtailed. In addition to a shortened life, confinement in an institution usually means loss of self-esteem, of freedom, and of useful activity.

For families and spouses, especially those without much money, the burden of caring for a disabled older person can be exhausting emotionally, financially, and physically. It is as painful to see a loved one decline as it is difficult to meet their needs, whether or not assisted by community resources. Yet the family often finds it even more heartbreaking to commit the patient to an institution.

Present public policies of relying primarily on institutional care without providing other options are as damaging to society as to the individual involved.

Noninstitutional alternatives in long-term care are drawing increased attention at the local, State, and Federal level, as they play a crucial role in either keeping people out, or assisting with the removal of people from institutions.

In response to studies indicating that the elderly compose a large percent of those confined to mental institutions, coupled with the growing interest in alternatives in long-term care, the States were asked about the portion of elderly residents in their mental hospitals and about possible placement in the community.

3. LICENSURE OF SMALL, HOMELIKE FOSTER CARE RESIDENCES

Question: Are there any small, homelike foster care residences for adults in your State? If so, does your State have a law licensing, certifying, or in anyway regulating these foster homes? Are there foster homes only regulated when they serve more or less than a certain number of people? If so, please elaborate.

Explanation: This question was asked because homelike residences are an important form of community-based care in some States.

4. APPROPRIATE ROLE FOR THE FEDERAL GOVERNMENT

Question: In your opinion, what should be the Federal role in protecting older people from abuse or dangerous circumstances caused by their own mental or physical decline?

Explanation: Because the elder abuse being explored by the committee occurs within the confines of the family, the Federal Government must be mindful of individual and States' rights in trying to deal with the problem. As stated in the working paper on protective services, cited earlier, protective services laws that have been enacted by a number of States are part Santa Claus, part ogre:

> On the one hand are the ideals of personal choice, individual freedom, and the respect for individual freedom, and the respect for individual differences. On the other are the principles that society has a duty to protect those unable to care for themselves and to protect itself from dangerous and destructive situations.

Aside from the question of individual rights, is the issue of States' rights. How can the Federal Government best proceed without circumventing the authority of the States?

State Responses Cataloged

1. STATE PROTECTIVE SERVICES LAWS

Before discussing the responses to the first question, it must be pointed out that adult protective services laws vary tremendously in scope. There is no clear guideline establishing what must be contained in a statute, or statutes, before a State can say it has an "adult protective services law." The committee attempted to compensate for the absence of a specific guideline by including a definition in its first question. In reading this section, it should therefore, be kept in mind that it simply catalogs the States' responses based on the committee's definition (see Introduction).

A. Half of the States Have an "Adult Protective Services Law"

Responses indicate that half (25) of the States have what the respondents consider an adult protective services law.

Different States, is should be noted, protect different people. Kansas, for example limits the provision of protective services to people in nursing homes or medical facilities operated by the State or Federal Government. Other States cover abuse or neglect of adults who live in the community.

In addition to the 25 States that have adult protective services laws, at least two, Nebraska and Minnesota, have laws that only require the reporting of abuse. No provision is made for the delivery of services. Other States have laws authorizing the provision of services, but do not require reporting.

The master chart, which follows, identifies which States indicated they have protective services laws and contains some descriptive information, as well.

B. Most Laws Passed in the Last 5 Years

The respondents were not asked when their State's adult protective services law passed. But, most volunteered the information. At least 16 of the laws were passed in the 5-year span from 1976–80; no fewer than 8 of these in 1977 alone.

C. Bills Before Many State Legislatures

Of the States without adult protective services laws, 14 have had adult protective services bills sponsored in their State legislatures, and 4 indicated that legislation is being developed.

II. THIRTY PERCENT OF THOSE IN STATE MENTAL HOSPITALS ARE ELDERLY

About 30 percent, 43,365 of the approximately 145,050 people in State mental hospitals, are elderly. Elderly in this case means age 60 or over. It is likely that it is a conservative estimate, because several States were only able to provide the committee with information on the residents age 65 and over.

It should also be noted that the figures provided the committee were not based on the population of State mental hospitals on one specific date or month. The time frame during which the figures were collected varies by a period of up to several months. Consequently, these figures should be viewed as estimates.

Not surprisingly, the percent of older people in State mental hospitals varies greatly: from a low of 1–3 percent in Alaska to approximately 50 percent in Pennsylvania and Virginia.

The portion of elderly residents who could be discharged if appropriate services were available varies still more: From almost no one in Wisconsin—which has long emphasized community-based mental health care—to almost all elderly State hospital residents in other States.

III. VAST MAJORITY OF STATES LICENSE SMALL, HOMELIKE FOSTER CARE RESIDENTS

As the master chart indicates, almost all States have laws requiring the licensure of small, homelike foster care residences for adults. While the name for this kind of facility varies from State to State, they are usually licensed under laws that are specifically developed for homes serving fewer than anywhere from two to five people.

IV. THE APPROPRIATE FEDERAL ROLE

Generally, the most frequent response indicated that the Federal Government could be most helpful by providing additional funding for the implementation of State protective services programs. In many cases, the importance of increase title XX funding was stressed.

The respondents also stressed the need for the Federal Government to encourage—or even mandate—States to enact protective services laws.

The need for information and training in the area was frequently mentioned, and suggestions were also made for policy changes.

The following outline summarizes States' comments on the appropriate Federal role. It is interesting to note that many of the comments are equally applicable for State government action.

Response	*States* [1]
I. Need for money:	
A. To fund protective services programs in States	8
B. To expand other in-home services	3
C. To create shelters	2
D. To fund research and demonstration projects	1
II. Need for State protective services laws:	
A. Encourage States to develop protective services legislation	3
B. Mandate States to develop and enact protective services legislation	5
C. Specifically mentioned national approach similar to that used in child abuse	2
D. Develop model protective services legislation	4
E. Establish uniform guidelines or standards for the provision of protective services	3
III. Need for information:	
A. Federal Government to provide technical assistance/training	4
B. Federal Government to establish clearinghouse	3
C. Need to educate public	2
IV. Policy changes:	
A. Allow title XX to offer services on an emergency basis for a limited time, regardless of income	1
B. Expand rights of elderly boarding home residents to be as broad as nursing home residents (i.e., ombudsman program)	2

[1] Number of States giving this response.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
Alabama	Yes. Passed in 1977		2,384	20 (476 people)		Establish standards and provide funding to enable the States to develop programs to prevent elder abuse through public education, outreach, and enforcement.	No homes/no laws	
Alaska	No		235	About 2 (5 people)	70 (2 people)	Provide technical assistance.		
Arizona	Yes. Passed in 1980		300	40 (120 to 125, people)	20 (about 80 percent would be in nursing homes)	Provide funding for protective services programs.	License foster homes which may not have more than 5 people.	
Arkansas	Yes. Passed in 1977		266	9 (25 people)		Expand medicaid regulations provisions for advocates and ombudsmen to boarding homes and other residential settings.		
California	No. No comprehensive law at this time.	Conservatorship law with due process provisions enacted in 1977.	5,314	9.7 (516 people)	Not known	Until authorities determine what is wisest way to treat elder abuse, it is difficult to determine which level of Government should take action.	License 4,207 "small family homes for adults" for people needing some care and supervision.	
Colorado	No. 1980 reporting bill introduced, but was not passed due to lack of funding.		984	11 (108 people)	Approximately 50 (60 people).	Develop legislation to insure "uniform provision of services" to abused elderly.	License homes from 1 to 15 people. State and counties supplement payments.	
Connecticut	Yes. Passed in 1978	If won't accept services, a conservator is appointed.	2,211	14 (314 people)	Not sure, but figure it would be substantial.	If anything, mandate that States develop some system for responding to elderly abuse.	License any facility that houses 2 or more elderly persons and provides more than room, board, and laundry.	

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
Delaware	No		1519	22 (114 people)	Only because 3 have a well-developed foster care program.	Gather and disseminate statistics and documentation of older people living in dangerous circumstances. Provide additional money for public advocacy in OAA for protective services.	Yes. Only those that serve 1 person are exempted.	
Florida	Yes. Passed in 1977		5,174	30 (1,527 people)	No information on 60 plus, but by July 1980, expect to refer 46 percent of 55 plus patients for discharge.	Provide funding to encourage States to develop protective services program through programs like title XX.	License foster homes and adult congregate living facilities.	Community based State programs for elderly in Florida include: (1) Home care, pays family or friend to care for elderly; (2) "Community care for elederly" to pay for services like respite care, day care, transportation.
Georgia	No. Bill introduced, but not reported by House Judiciary Committee.	Unless can find a guardian cannot intervene on behalf of older person—guardianship statute revised in 1980—Department of Human Resources may be guardian.	5,569	21 (1,175 people)	25 to 50. An additional 35 percent if nursing homes considered appropriate.	Make sure Federal laws and regulations don't interfere with a person's rights. Cites legislation empowering U.S. Attorney General to intervene when nursing home residents' rights are violated as superb.	License homes according to size.	
Hawaii	No. Legislation introduced in 1975 but did not pass.		255	10 (22 people)		Legislate mandatory minimum standards for States in provision of protective services. Provide for research and training grants, as per child abuse.	License homes according to number served (4 is break-off number for various homes).	

Idaho	No. Draft legislation developed but not introduced.	Have a "progressive" guardianship law.	232	22 (51 people)	36 (8 people)	Direct Department of Justice to develop model adult protective law.	Have shelter care licensure for facilities caring for 3 or more people.	Have trouble finding guardians for poor people.
Illinois	No. Bill before Illinois Legislature would create special legislative commission to study elderly abuse.	Have a new guardianship and advocacy program, which became effective in 1980.	10,240	7 (685 people) (was 10,000 a decade ago).	Only residents who cannot be cared for in the community are cared for in the hospital.	Encourage examination, review and identification of elder abuse.	Have a small program, only 340 people statewide. VA has about 250 people but there is no licensure law just department standards (Public Health Department).	
Indiana	No. But, commission on aging is working on one.	----------	5,060	17 (865 people)	No answer	Provide for public education.	Have licensure laws for various sized homes.	
Iowa	No. No law or pending legislation.	----------	1,040	22 (228 people)	100	Establish firm criteria in guiding States in protecting adults.	License residential care facilities for 4 or more beds.	
Kansas	Yes. Became effective July 1, 1980. But is limited to people in nursing homes or medical facilities operated by State or Federal Government. Also have protection from abuse act.	----------	[3] 1,200	Approximately 10 (120 people).	95 percent could return, depending on definition of support services.	Develop model legislation on abuse reporting and hearings to show that the problem exists. Promote a program for alternate living arrangements.	License: "1-bed adult care homes" as well as "2-bed" homes. Also license boarding homes for 3 or more people.	Abused adult can either seek redress under criminal statutes or from "protection from abuse act" if they are abused by a family member.
Kentucky	Yes. Enacted 1976, revised 1978 and 1980. The law requires reporting and provides for emergency services for those who can't care for themselves.	----------	789	20 (157 people)	33	Set standards and encourage States to enact adult protective services laws.	Have "family care homes." Require licensing if care for 2 to 3 people. If 3 or more are licensed as personal care homes.	
Louisiana	No. But a bill is before the legislature.	----------	2,093	15 (317 people)	No answer	Develop national clearinghouse for elder abuse information. Fund protective services programs. Designate people on national and regional levels as consultants.	No ----------	

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
Maine	Yes. Involuntary protective services must be provided through public or private guardianship.	----------	630	40 (252 people)	32 to 38.2 percent could be returned according to a study.	Fund and require State protective services laws.	Adult foster home program licenses homes for 4 or fewer people.	
Maryland	Yes. Became effective in 1977.	----------	3,637	36.3 (1,320 people)	38 (23 percent in nursing home, 15 percent in family setting).	Federal Government should require all States to enact guardianship laws.	No statewide licensure program, but counties do license, though standards vary.	
Massachusetts	No. Legislation before legislature, but already have a law "dealing with prevention of abuse in general."	----------	[2] 2,000	30 (600 people)	Very few	Should fund more for title XX. The Federal Government should act as a clearinghouse for information on elder abuse.	Have some facilities and these are subject to State building codes.	
Michigan	Yes. Act No. 136 of the Public Acts of 1976 and sec. 68 of 1978–79 Appropriations Act. Bill in 1980 would require reporting, confidentiality and immunity.	New probate court code and mental health code gives probate courts the authority to appoint guardians and conservators of adults who are unable to manage finances.	[3] 4,807	16 (759 people mentally incompetent).	28.1		Have 3,012 adult foster care facilities licensed to serve 18,836 people.	Goal of guardianship and mental health law is to maintain person in least restrictive setting.
			[4] 4,974	3 (151 people mentally retarded).	26.9			Law does not require reporting.
Minnesota	Reporting law only. Sponsored for first time and passed in 1980.	----------	4,893	8 (387 people)	1 or 2 people, if any	Develop a national policy for dealing with adult abuse. Make sure that all agencies working on the problem coordinate work.	No State licensure law in foster-type homes.	Minnesota has been working on delnstitutionalizing its mental hospitals since the mid-1950's. Will soon be closing one, and possibly more.

Mississippi	No. Bill introduced in 1980 but not reported out of committee.		2,285	39 (891 people)	60 percent with nursing homes 10 to 15 percent without.	Funding of protective services. Set minimum "care" standards to apply in the absence of State law.	No licensure of boarding homes, though they exist. No foster care-type homes. Do license personal care homes.
Missouri	Yes. Passed in 1980. Consent required for the provision of services, unless a person is first declared incompetent.	No legal right to intervene against a person's wishes.	[5]2,631	26.7 (704 people) 8 (29 people of those in mental health centers)		More emphasis should be placed on prevention. Need more money for rural health needs.	Bill before legislature would pay relatives to provide foster care.
Montana	Yes. Statute does not define abuse, exploitation, neglect, etc. Does not have a reporting provision.	Use guardianship law to provide protective services involuntarily, use public or private guardians.	514	31 (218 people)	13 (67 people)	Support budget requests for title XX protective services and require States to pass model protective services legislation.	License for 4 or more people.
Nebraska	Has a reporting law, but services to be provided are in directives issued by Division of Social Services, not in law.	Cannot provide services involuntarily.	582	13 (76 people)	Respondent said question is "moot."	Change title XX to allow social services to be provided without regard to income on an emergency basis for a limited time (90 days). Require resources to be coordinated.	Have 260 licensed adult family homes. Have 26 custodial foster homes with 849 beds for more structured environment.
Nevada	No. Bill introduced in 1979, but did not pass. Bill dealt with people over 18.	----------	152	12 (17 people)	Not applicable. State hospital beds are for acute/crisis care only. Don't have chronic back-ward patients.	----------	No licensure law. But welfare division certifies homes that care for 3 or more people who receive State SSI supplements.
New Hampshire	Yes. Enacted in 1977. Must petition for guardianship or temporary guardianship to provide involuntary protective services.	----------	782	32 (251 people)	----------	----------	Regulate all homes that provide care or supervision to adults; but not those that provide room and board.

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
New Jersey	No. A reporting bill is being reviewed by the Assembly.	----------	3,929	42 (1,645 people)	----------	----------	New law requires that boarding homes, rest homes, or other homes for the sheltered care of 4 or more adults be subject to Stato regulation, approval and inspection. But, have no small home-like foster care residence for adults.	
New Mexico	No. Bill sponsored in 1979, but did not pass.	Provision in probate code is only legal authority for providing adult involuntary protective services.	237	27 (64 people)	10	Should mandate and fund same protection for adults as for children.	No foster care exactly but have many adult residential shelter care and boarding homes with 6 or fewer residents.	
New York	Yes. In 1979 it was expanded to cover all individuals incapable of managing themselves, not just SSI recipients.	A recent "State task force on protective services for adults" targeted involuntary intervention as one of the major areas for study. Now can't provide services to someone who won't accept them, but legislation is pending.	25,041	53 (13,288 people)	----------	Strongly emphasize protective services in Federal legislation. Fund protective services with local and State flexible allotment.	----------	Not sure should go route of child abuse act, because not sure of program's value. Therefore, go with demonstration programs first. Mentioned the importance of housing and home services in solving problems.
North Carolina	Yes. Contains reporting provision.	----------	3,375	35 (1,181 people)	75 to 80	Eliminate title XX ceiling.	License family care homes for 2 to 5 people.	
North Dakota	No. Agency personnel are working on a draft bill.	----------	564	34 (192 people)	----------	Needs to take an active role as in child abuse. Do national conference on topic.	Have a licensure law but not a well established statewide foster care program.	
Ohio	No. Bill before legislature now, but was not passed due to gap in coverage, which left the 18–54 yr. olds uncovered.	----------	11,074	20 (2,166 people)	----------	----------	License foster homes for not more than 5 people, at least 1 who receives SSI. Group home for 6 to 16, licensed, at least 1 on SSI.	

Oklahoma	Yes. Law passed in 1977. "Elderly" person is defined as someone 65 or older. Authorizes involuntary protective services with a court order, if person lacks capacity to consent to services and is suffering from abuse, neglect, or exploitation presenting a substantial risk of death or immediate serious harm to himself.	----------	1,518	26 (392 people)	Not known.	Federal role should be providing grants to States to study the problem and implement requirements based on State need.	No law has been implemented due to lack of funding and documentation of need.	
Oregon	Yes. Statutory authority is only 1 sentence long. Simply directs State agency to develop regulations for the provision of "social services, including protection, to those individuals in need of, or who request such services."	Guardianship, etc., may be used to provide protective services without consent.	1,192	6.9 (have been stressing community placement) (82 people).	2	Encourage States to develop comprehensive protective services programs. Increase title XX funding for protective services.	Has 850 certified adult foster care homes, for 5 or fewer people.	State is currently researching possibility of establishing a social service system to serve abused elderly.
Pennsylvania	No. But several bills introduced. Now provide protective services to people involuntarily through mental health procedures act or incompetent estates act.	----------	10,500	50 (5,250 people)	No answer, but currently discharge less than 1 percent of people over 60.	----------	State has a domiciliary care program, certified by area agencies on aging for SSI recipients. Are also 30 county-operated foster homes for those residents who are usually healthier than domiciliary care.	
Rhode Island	Yes. Provide protective services only on voluntary basis. Reporting bill filed in 1980, as was legislation creating limited guardianship and conservatorship.	----------	666	19 (127 people)	15 to 20 people	----------	Have no group homes just for the elderly, but all group homes are licensed.	
South Carolina	Yes	----------	3,550	43 (1,537 people)	28 (427 people)	Conduct workshops in States that don't have protective services laws. Develop model legislation.	Adult residential facilities and licensed for 2 or more.	
South Dakota	Yes	----------	457	40 (183 people)	50	----------	License 183 facilities	

See footnotes at end of table.

MASTER CHART.—SUMMARIZATION OF STATE RESPONSES TO PROTECTIVE SERVICES SURVEY—Continued

State	State protective services law?	Comments on protective services, guardianship or conservatorship laws	Number of people in mental hospitals	Percent of those elderly	Percent who could return to community	Role of Federal Government in protective services	State foster care licensure law?	Other
Tennessee	Yes. Passed in 1978. Applies to anyone 18 or over, who because of mental or physical dysfunctioning or advanced age (60 plus), is unable to care for self (paraphrased).	Court can order that services be provided involuntarily in life threatening situations. Requires that the person have counsel.	2,218	39.5 (895 people)	5		Depending on kind and size of home, have a variety of licenses, starting with homes with 1 or more unrelated people.	Also have State homes operated by department of Human Services and licensed by Department of Public Health.
Texas	No. But several bills have been introduced.		1,518	27.48 (417 people)		Provide funding	License approximately 200 foster family care homes with up to 3 people. Homes with 4 or more are licensed as long term care.	
Utah	Yes. Has a law (since 1977) that spells out provisions for assisting elderly people who will not consent to provision of protective services.		310	16 (50 people)	50 (25 people)	Provide funding. Also provide consultive services and act as a clearing house for information and training.	Do not license, but certify and approve adults foster homes for up to 3 people.	
Vermont	Yes. Law passed April 1980.		286	29 (83 people)	45 total people. 15 people to nursing homes. 30 people to other settings.	Educate country about problem. Mandate that each State enact protective services legislature.	License "community care homes."	
Virginia	Yes. Passed 1977		4,876	49.9 (2,433 people)	25 (608 people)	Encourage States to enact protective services laws. Establish national policy for continuance of in-home services, developed in concert with voluntary sector. Simplify coordination by medical and social services and case management. Channel money away from institutions to community-based care. Initiate national public awareness effort.	License homes for 4 or more people.	

Washington	No	Can provide supportive treatment under: Guardianship (also limited guardianship); involuntary commitment; reporting and investigation required of nursing homes.	3,960	9.3 (371 people)	[6] 18.7	Housing: Assist in creation and funding of shelter facilities. Training of adult protective services staff and care givers of abused adults. Research-demonstration projects.	License adult family homes that serve a maximum of 4 people. There are 400 homes, 235 of which have a contract with State.	
West Virginia	No. Bills introduced for past 5 years, but since Department of Welfare can provide service it thinks is necessary, it has issued guidelines for delivering protective services.	No agency has authority to provide services involuntarily (has been very controversial issue in legislation).	2,224	28 (623 people)	Not sure	Require States to pass protective services law, which should require that a lead agency be designated.	Has 780 approved adult family care homes for 1 to 3 elderly people.	Have trouble recruiting adult family care homes because reimbursement is so low ($195 to $265) per month.
Wisconsin	Yes. Passed in 1973. No reporting provision.	Can only be given services involuntarily if have a guardian, however, may be placed under protective placement if there is a probability of irreparable injury at death.	[2] 500	5 (25 people)	None. Place much emphasis on community mental health care.	Provide flexible block grants, so that States can fund services they think are important.	License adult family homes for 1 or 2 and community-based residential for 3 or more.	Think Federal Government should assist States develop non-institutional support service. Now availability of funds determines programs, not appropriateness.
Wyoming	No. State is working on preparing one that will deal with abuse of all people, not just elderly.		279	22 (60 people)	25 (15 to 20 people)	Establish a Federal adult abuse registry, develop training sessions and resource material and funding for such projects.	In accordance with the Key's amendment in Federal law (Public Law 94-566) they have established minimum standards for foster homes serving SSI recipients.	

[1] Also has a 122-bed secure intermediate care facility.
[2] Approximately.
[3] Mentally incompetent.
[4] Mentally retarded.
[5] In addition 359 in mental health centers.
[6] 18.7 percent is as follows: 3.2 percent could be independent, 9.1 percent to congregate care or nursing homes, 6.4 percent could go to residential care if had special mental health treatment.

D. Legislative Followup

When considering the Domestic Violence, Prevention and Services Act of 1980 (S. 1843), on September 4, the Senate adopted an amendment offered by Senator John Heinz of Pennsylvania, to fund a study on the nature and incidence of elder abuse. The study was to have been conducted by the Secretary of the Department of Health and Human Services and delivered to Congress within 18 months, along with any recommendations deemed appropriate.

While the House approved a conference report that worked out differences between the House and Senate versions of the domestic violence legislation, the Senate never acted on the compromise. As a result, the legislation died when the 96th Congress adjourned in December.

Representative Mary Rose Oakar of Ohio introduced H.R. 7551 on the same day as the aforementioned joint hearing on "Elder Abuse" (June 11, 1980). Her bill would create a National Center on Adult Abuse and provide financial assistance for programs for the prevention, identification, and treatment of adult abuse, neglect, and exploitation.

H.R. 7551 would establish a National Center on Adult Abuse similar to the National Center on Child Abuse and Neglect and the Office of Domestic Violence. This center would compile an annual research summary, act as an information clearinghouse, provide technical assistance, conduct research, and award grants for demonstration or service programs and projects.

H.R. 7551 was referred jointly to the Committees on Interstate and Foreign Commerce, and Education and Labor, but was not considered by either committee before adjournment of the 96th Congress.

III. FOOD STAMPS

The second session of the 96th Congress began and ended with notifications to the Congress by the Secretary of Agriculture that the food stamp program was in financial trouble and benefits would have to be terminated for several months unless supplemental appropriations were approved. Plagued by soaring food prices and expanding benefit rolls due largely to a higher rate of unemployment, the program's spending caps for both fiscal years 1980 and 1981 had to be legislatively increased.

The eligibility rolls increased to 22 million persons by the end of 1980. Of these 22 million, the U.S. Department of Agriculture (USDA) estimated that approximately 7.6 percent or 1.7 million persons, were aged 60 and over. Early USDA figures on enrollment data after the elimination of the purchase requirement (amount previously charged for coupons) show that elderly participation increased approximately 32 percent as compared to 14 percent for nonelderly recipients. This increase in elderly participation was attributed to the elderly's inability to buy their way into the program in the past when a substantial amount was required to purchase the coupons.[6]

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[6] Public Law 95–311 enacted in 1977 eliminated the purchase requirement. However, final regulations governing this change were not issued until late 1978 and 1979 and, therefore, descriptive data on the impact are only now being collected. A more detailed USDA report on the impact of eliminating the purchase requirement is expected in February 1981.

A. Food Stamp Amendments of 1980

The Food Stamp Act Amendments of 1980 (Public Law 96–249) were signed into law on May 26, 1980. Major provisions of the new amendments included increasing the spending cap to $9.49 billion for fiscal year 1980 and $9.7 billion for fiscal year 1981. Modifications aimed at curtailing food stamp spending increases were also added.

Changes in the food stamp program affecting elderly participants are described below:

—Public Law 96–249 eliminates the twice-a-year cost-of-living increases in the benefit levels, standard deduction and the excess shelter deduction, and authorizes an annual increase to be adjusted in January of each year.

—The law reduces the assets limitation from $1,750 to $1,500 per household *except* for households with two or more persons with an elderly person whose limitation shall remain at $3,000.

—States have the option of determining program eligibility on a retrospective rather than prospective basis. This option allows the food stamp office to use one's previous month income for determination instead of income estimated for upcoming months, which will assist States in reducing the error rate in benefit and eligibility determinations and thus save dollars.

—Recipients are allowed to disregard income received as energy assistance payments as countable income.

—The law exempts vehicles used for transporting physically handicapped individuals from being counted as assets.

—The special medical deduction for elderly persons is expanded by allowing persons 60 and over and the disabled to deduct all allowable medical expenses above $25 a month when determining their net income for program eligibility and benefit level. The special deduction was also expanded to cover medical expenses of spouses, regardless of age or physical condition.

—Households whose members are all recipients of SSI can apply for participation in the food stamp program by filling out simple application forms in local or district Social Security offices.

—The 1980 amendments require disclosure of certain information regarding taxes from the Social Security Administration and unemployment offices to the USDA and State food stamp offices to determine food stamp eligibility.

—Several provisions are included in the new law which provide incentives for States to reduce their error rate and thus save millions of dollars. In addition, penalties are prescribed for States which fail to reduce their error rate below the national rate within a given period of time.

B. Funding Problems of 1980

In 1977, Congress authorized and extended the Food Stamp Act through fiscal year 1981 (Public Law 95–311). At that time, the Congress and administration made projections for the program through 1981 in order to set spending caps for the program.

By early 1980, it was evident that food prices had risen three times higher than projected for 1980 and the unemployment rate of 7 percent was approximately a percentage point above earlier projections.

Therefore, it was crucial for the Congress to provide supplemental appropriations for the program or face the program's inability to provide benefits for the last few months of the fiscal year. In May 1980, Public Law 96–423 provided for an additional $2.6 billion to bring the total available for the program to $8.8 billion. However, by June it became apparent that additional funding would be needed to continue benefits through September 30, 1980. Congress was forced to approve an additional $400 million to the program bringing the total 1980 appropriation to $9.2 billion (Public Law 96–304).

This was not the end. During the final hours of the 96th Congress it again became apparent that the $9.7 billion approved for fiscal year 1981, would be insufficient to cover projected benefits for the whole year. Debate in the Senate resulted in nothing substantial, but it is indicative of the problem which will continue to plague the 97th Congress.

IV. CRIME AND THE ELDERLY

A. The Problem

There is a substantial body of evidence suggesting that the elderly of this country are the least likely age group to be victimized by crime. It is generally recognized, however, that there is a certain distinctiveness about the elderly as crime victims. Various demographic trends in this country project the ballooning of the elderly population over the course of the next 50 years, from 11 percent of the present population to a possible 22 percent of the population by the year 2030.[7] The sheer numbers of older people in the United States demand an examination of this problem and the characteristics of older Americans which set them apart from the total crime picture. Some of these distinctive features include the following factors:

—The economic impact of crime on elderly victims is generally more severe than on younger people. Many older people live on fixed, relatively low incomes, and they have little hope of recouping financial loss through future earnings.

—Older people are more likely to live in high-crime neighborhoods, because of either limited income or reluctance to leave inner-city neighborhoods in which they have lived for so long. The elderly may choose to live at risk in unsafe surroundings because they find the familiar setting comfortable in a world that seems to change daily. Elderly people are also more likely to live alone.

—The natural handicaps of aging make the elderly obvious targets for criminals. Often unsteady and slow moving, they can easily be pushed off balance and fall. Hearing and vision impairments render an older person more susceptible to surprise attack.

—Since older people tend to be concentrated in inner-city neighborhoods, often separated from family members, they rely on public transportation, or walk to carry on the essential tasks of everyday living.

—It is common knowledge on which days social security checks are mailed and received. At this time of the month, seniors are more likely to be carrying around large sums of cash, thereby increasing their vulnerability.

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[7] U.S. Bureau of the Census. "Current Population Reports," series P–23, No. 59, and series P–25, No. 704.

Possibly the best indicator of the incidence of criminal activity is the National Crime Panel, which is a program established by the Law Enforcement Assistance Administration to develop information not otherwise available on the nature of crime and its impact on society by means of victim surveys of the general population. Data collected by the National Crime Panel (NCP) has two distinct advantages over crime statistics compiled by the Federal Bureau of Investigation (FBI). NCP surveys are the only studies of crime at the national level which keep statistics on a uniform basis. The FBI statistics are an assorted accumulation of facts kept by thousands of law enforcement agencies across the country. This makes comparison of raw data virtually impossible because criteria for gathering this information is not uniform. Second, within each locality surveyed, NCP samplings are made of household and commercial establishments representative of the area, in order to elicit information about experiences, if any, with certain crimes of violence and theft. Events that were not reported to the police are included, providing a more complete picture of actual victimization rates.[8]

The victimization studies show that the highest rate of victimization occurs in the young age groups, with each older group having progressively lower rates. Persons 65 and older have the lowest rates, especially for violent crimes such as rape, robbery, and assault, being victimized at a rate of 9 per 1,000 persons age 65 and over. The combined victimization rate for all three crimes for the general population was 34 per 1,000. A summary of the pertinent data from the victimization survey is shown in the following table:

TABLE 1.—PERSONAL AND HOUSEHOLD CRIMES: VICTIMIZATION RATES FOR THE GENERAL AND ELDERLY POPULATIONS

Type of crime	General population[1]			Elderly population[2]		
		Percent change			Percent change	
	1973 rate	1973–74	1974–75	1973 rate	1973–74	1974–75
Personal crimes:						
Crimes of violence	34	+1.5	−0.4	9	+5.5	−13.5
Rape	1	+4.3	−7.1	[3] 2	+66.7	−70.0
Robbery	7	+6.4	−5.6	5	−21.6	+10.8
With injury	2	+.4	−9.0	2	+3.8	−36.8
Without injury	5	+9.6	−4.0	3	−36.7	+57.1
Assault	26	+.1	+1.5	4	+46.0	−30.5
Aggravated	10	+3.3	−7.4	1	+46.2	−6.5
Simple	16	−2.2	+7.8	2	+45.9	−41.8
Crimes of theft	93	+4.2	+1.0	23	−1.9	+11.9
Personal larceny with contact	3	+1.6	−1.0	4	+5.5	−4.9
Personal larceny without contact	90	+4.3	+1.0	19	−3.2	+15.1
Household crimes:						
Burglary	93	+1.3	−1.3	55	−1.2	−1.0
Household larceny	109	+15.6	+1.5	48	+22.5	+1.3
Motor vehicle theft	19	−1.7	+4.0	5	+5.6	+8.6

[1] Rates for personal crimes are per 1,000 persons age 12 and over. Rates for household crimes are per 1,000 households.
[2] Rates for personal crimes are per 1,000 persons age 65 and over. Rates for household crimes are per 1,000 households headed by persons age 65 and over.
[3] Less than 0.5 per 1,000.

Source: U.S. Department of Justice, Law Enforcement Assistance Administration, Criminal Victimization in the United States, 1973 (tables 2, 4 and 16). U.S. Department of Justice, Law Enforcement Assistance Administration, Criminal Victimization in the United States, A Comparison of the 1973 and 1974 Findings (tables 1, 4, 8 and 9). U.S. Department of Justice, Law Enforcement Assistance Administration, Criminal Victimization in the United States, A Comparison of the Findings (tables 1, 4 8 and 9).

[8] U.S. Department of Justice. Law Enforcement Assistance Administration. "Programs for Senior Citizens," February 1978.

In only one crime category—personal larceny with contact, which includes "street crimes" such as purse snatching and pickpocketing—are older persons victimized at a greater rate than the general population. Additional survey findings of the National Crime Panel indicate that the elderly are slightly more likely to be injured as the result of criminal activity which manifests itself in a higher rate of hospitalizations for persons 65 and older.

TABLE 2.—PERCENT OF VICTIMIZATIONS IN WHICH VICTIMS SUSTAINED PHYSICAL INJURY, BY AGE OF VICTIMS AND TYPE OF CRIME, 1977

Age	Robbery and assault	Robbery	Assault
12 to 15	31.2	24.4	32.9
16 to 19	31.6	33.0	31.4
20 to 24	31.7	40.6	27.1
25 to 34	26.9	41.3	24.3
35 to 49	29.0	31.3	28.3
50 to 64	25.5	31.3	22.5
65 and over	35.3	57.5	16.6

Source: U.S. Department of Justice, Law Enforcement Assistance Administration, Criminal Victimization in the United States, 1977 (table 67).

TABLE 3.—PERCENT OF VICTIMIZATIONS IN WHICH VICTIMS RECEIVED HOSPITAL CARE, BY AGE OF VICTIMS AND TYPE OF CRIME, 1977

Age	Crimes of violence	Robbery	Assault
12 to 19	6.4	6.2	5.8
20 to 34	7.4	10.0	6.7
35 to 49	9.0	7.3	8.8
50 to 64	8.5	7.6	9.0
65 and over	8.1	14.9	2.7

Source: U.S. Department of Justice, Law Enforcement Assistance Administration, Criminal Victimization in the United States, 1977 (table 71).

The data also indicates that there is a positive correlation between increased age and chance of victimization at the hands of strangers. In 82 percent of the surveyed crimes of violence against elderly persons, the offender was identified as a stranger, compared to 66 percent among victims in the general population.

Taken as a whole, the survey findings would indicate that older persons are no more "at risk" than are younger age groups. However, these statistics can in no way minimize the severity of the impact of crime on the elderly—the fear, apprehension, and terror that foster a fortress mentality, keeping many older persons virtual prisoners in their own homes and apartments. Considering the total age distribution, it is indeed paradoxical that while senior citizens are the least likely age group to be victimized, they tend to express the highest level of fear.[9] A recent study conducted at Pennsylvania State University with funding from the Andrus Foundation of the American Association of Retired Persons, revealed that 8 percent of 2,000 elderly citizens surveyed said they actually cross the street or change their direction of travel

[9] Cook, et al., "Criminal Victimization of the Elderly," Gerontologist, August 1978.

just to avoid teenagers and restrict their activities to morning or early afternoon hours to stay clear of school-age hoodlums.[10]

For older people, fear of victimization is probably the most debilitating aspect of crime. This theory is supported by a number of researchers who feel that while the fear of crime among the elderly is real and pervasive, this fear is even more of a problem than actual victimization. In early 1974, the National Council on Aging commissioned Louis Harris & Associates to conduct a comprehensive national survey on the problems of the elderly. Their survey showed that the elderly ranked "fear of crime" as the most serious problem confronting them; 23 percent of those over 65 said that fear of crime is a "very serious problem" for them personally, while poor health elicited a 21 percent response rate. [11] In 1972, the National Retired Teachers Association/American Association of Retired Persons (NRTA/AARP) in conjunction with the University of Michigan, conducted a national survey of 4,500 elderly people to determine their needs and concerns. The survey indicated that fear of crime ranked second, following only inadequate food and shelter. In 1973, NRTA/AARP and the University of Southern California undertook a second national survey of 77,000 elderly people. Again crime was ranked as the second item of greatest concern, following food and shelter.[12]

Virtually all surveys on the fear of crime indicate that women have a higher rate of fear than men, that elderly blacks are more afraid of crime than elderly whites and that central city residents have a significantly higher fear of crime in their immediate neighborhoods than do residents of an urban middle class municipality or a suburban retirement community.[13] Robert J. Smith notes, in "Crime Against the Elderly: Implications for Policymakers and Practitioners," that residence in an inner-city setting is one characteristic of older people that causes them to become targets of criminals. The elderly city resident, cognizant of their heightened vulnerability, responds by withdrawing from the fearful environment and remaining behind locked doors. The net result is an obvious reduction in victimization but also a less apparent diminution in the quality of life.

B. Victim Assistance Legislation

The primary legislative thrust in the 96th Congress with respect to crime and the elderly was in the area of victim compensation. This trend has resulted from a growing interest in providing compensation for the innocent victims of crime through programs financed by the Federal and/or State governments.

A recent study by the Center for Criminal Justice and Social Policy at Marquette University examined the needs and problems of citizens in their roles as victims and witnesses, both in relation to the criminal act and citizen participation in the criminal justice system. The study

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[10] Godbey, Geoffrey, Crime Control Digest, Mar. 3, 1980.

[11] Harris, Louis & Associates, Inc., "The Myth and Reality of Aging in America," Washington, D.C., National Council on Aging, 1975, p. 31.

[12] U.S. Congress. House. Select Committee on Aging, Subcommittee on Housing and Consumer Interests, "In Search of Security: A National Perspective on Elderly Crime Victimization," committee print, committee publication No. 95–8, Washington, U.S. Government Printing Office, 1977, p. 38.

[13] Sundeen, Richard A. and James T. Mathieu, "The Fear of Crime and Its Consequences Among Elderly in 3 Urban Communities," the Gerontologist, vol. 16, June 1976, p. 218.

found that victims frequently incur a number of financial costs not reimbursed by insurance. The average nonreimbursed medical costs for 300 victims experiencing physical injury was about $200. The average noninsured costs for property replacement and repairs was $373 as a result of a crime-related incident. While nearly two-thirds of victims are likely to have some insurance protection, one-third, largely in the lower income population, do not.

At least 27 States have enacted programs to compensate victims of violent crimes. These programs vary widely in the type and adequacy of benefits provided. In addition, many States are facing serious budgetary problems making it difficult to begin or continue funding victim compensation programs. As a result, the propriety, desirability, and feasibility aspects of such programs have been questioned.

Proponents of governmental compensation for crime victims base their arguments on various rationales. One justification is "society's failure to protect." This theory holds that when an individual has been injured by a criminal act, society has failed to carry out its responsibility to protect that person. A second theory behind crime victim compensation programs is the need to combat the individual citizen's sense of alienation and anger at society and to encourage citizens participation with law enforcement agencies. Finally, proponents argue that if there is Federal interest in helping States prevent crime, to apprehend and imprison criminals, and to house and facilitate the rehabilitation of prisoners, then there also should be Federal interest in helping States to assist the victims of those criminals.

Opponents of Federal assistance to State victim compensation programs argue first that although compensating crime victims can be a legitimate governmental activity, such programs are essentially charitable in nature and not the result of any absolute governmental liability to its citizens. Second, since the Federal Government has no responsibility for the enforcement of a State's criminal laws, it therefore has no responsibility for compensating its victims.

Opponents are also concerned about the long-range costs of such a program. The Judiciary Committee, in reporting the Victims of Crime Act of 1979, estimated that the cost to the Federal Government would be $13 million in fiscal year 1981, $16, $17, and $18 million in fiscal years 1982, 1983, and 1984, respectively. The LEAA issued a report concluding that *total* costs for a national program could range from $144 million to $261 million.[14]

In the 96th Congress, legislation was introduced by Senator Edward M. Kennedy, then chairman of the Senate Judiciary Committee, and by Representative Peter Rodino, chairman of the House Judiciary Committee (S. 190/H.R. 1899). Following markup of H.R. 1899 by the House Subcommittee on Criminal Justice, a clean bill (H.R. 4257) was introduced and favorably reported by the full Judiciary Committee on February 13, 1980 (H. Rept. 96–753).

S. 190 and H.R. 4257, as reported, were substantially similar. Both would have provided grants to qualifying State victim compensation programs in an amount equal to 25 percent of the cost of compensating

[14] McClure, Barbara, "Crime: Compensation for Victims," Congressional Research Service, Library of Congress Issue Brief No. IB74014.

victims of State offenses and 100 percent of the cost of compensating victims of Federal offenses. Neither would have provided funds for administrative costs and certain other expenses. The maximum award to any one victim or dependents reimbursable under the Senate bill would have been $35,000; the maximum reimbursable award under the House bill was $25,000. The Senate bill would have prevented States from basing eligibility for compensation on the financial means of the claimant; the House version had no such requirement.

Major legislation to reform the Federal criminal code (S. 1722) would also have established a program to compensate victims of crime over which Federal jurisdiction exists. The Handgun Crime Control Act of 1979 (S. 1936/H.R. 5823) would have provided for Federal grants to State victim compensation programs for benefits paid for personal injury and death resulting from handgun crimes.

Unfortunately, none of the above-mentioned legislative measures were approved by the 96th Congress.

C. Committee Hearing on Crime and the Elderly

On June 23, 1980, Senator Pete V. Domenici, then ranking minority member of the Senate Special Committee on Aging, held a hearing in Albuquerque, N. Mex., entitled, "Crime and the Elderly: What Your Community Can Do." The hearing was designed to increase public awareness of the impact of crime on the elderly and to help identify issues for both the reauthorization of the Older Americans Act and the White House Conference on Aging in 1981. Senator Domenici noted that:

> There is no question in my mind that criminal victimization remains a continuing problem for older Americans. When we consider older persons and crime, two key factors come into play—first, the elderly person's heightened vulnerability, and second, the fear that flows from awareness of their condition. There is no section of the Older Americans Act that directs its attention to the subject of crime and the elderly. There is no section that directs its attention to local law enforcement training, community participation, volunteerism by senior citizens in crime prevention and crime information. I urge those of you present today to give some real thought to the feasibility of including a section in the Older Americans Act that focuses on this aspect of the serious problem that you have talked about here today—the suggestion inherent in your discussion—better use of senior citizens in helping other seniors.

Participants included State and local aging professionals, law enforcement officials, and elderly citizens who related their own experiences as victims of crime. In conjunction with and following the hearing, the National Retired Teachers Association/American Association of Retired Persons, the New Mexico Law Enforcement Academy, and the New Mexico State Agency on Aging sponsored a training workshop to promote greater sensitivity to the special needs of older Americans and to explore, in detail, practical, preventive measures for implementation on a statewide or local level. These included:

(1) Providing escort services.
(2) Instituting neighborhood watches/volunteer patrols.
(3) Providing home security improvements.
(4) Designing new public housing to help reduce the incidence of crime; and
(5) Providing special training to police to sensitize them to the needs of older people.

D. Dismantling the Law Enforcement Assistance Administration

The Law Enforcement Assistance Administration (LEAA) was established 12 years ago in an effort to coordinate the Nation's ineffective and disorganized anticrime efforts. Since that time, the LEAA has spent over $7.5 billion in helping State and local officials fight crime—apparently to little avail. In a move reflecting a new wave of fiscal austerity, Congress cut LEAA's budget as part of its attempt to balance the budget. Its main component—grant programs to the States—was wiped out completely, from more than $400 million to zero.

Critics of the LEAA cite its inability to reduce crime, its lack of strong leadership, goals and standards of performance, wasteful spending, and its impetus to a vast new bureaucracy of "criminal justice planners." Two years ago, the Government Accounting Office (GAO) issued a report, noting that LEAA initiated over 100,000 projects that were, at best, wasteful and frequently illegal. A recent Criminal Justice and the Elderly Newsletter (spring 1980), on the other hand, noted that organized elderly in particular have applauded LEAA's support of two major reforms: Programs of community crime prevention and victim assistance programs—neither one of which existed prior to LEAA's creation—and that both programs are making substantial headway in reducing the devastating effects of criminal activities. In addition, even though the LEAA spent more than $7 billion dollars over the course of its 12-year history, this amount is less than 5 percent of all criminal justice spending.

President Nixon made the alarming crime statistics a major issue during a time when America was witnessing increased restlessness and riots in major cities. In fact, one of LEAA's first grants was for riot control equipment for police.

> The agency was never able to escape its image as a wasteful bureaucracy that funded armored cars, night sticks, and tear gas, but did nothing to lower the crime rate.[15]

With the era of agitation apparently in the past, Congress diverted LEAA moneys to programs with rather weak constituencies such as prisons, social programs, and the court system—each focal point clearly failing to deter crime trends. In 1980, when the Office of Management and Budget sent out word to the various departments that budget cuts were necessary, the Department of Justice had only one grant program to turn to—the Law Enforcement Assistance Administration.

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[15] Babcock, Charles R., the Washington Post, "By Bits and Pieces, a Crime-Fighting Program Nears Extinction," Nov. 29, 1980, p. A3.

At present, the agency has nearly $1 billion appropriated to various State and local agencies which will continue to fund certain programs until that money is exhausted. A few programs initiated by the LEAA will remain functional even after LEAA funds are no longer available. These programs include juvenile justice, research, and statistics-gathering programs.

V. CETA—COMPREHENSIVE EMPLOYMENT AND TRAINING ACT

Prior to 1973, a number of categorical federally controlled employment programs were authorized by the Manpower Development and Training Act (MDTA) and the Economic Opportunity Act (EOA). In 1973, with the passage of the Comprehensive Employment and Training Act (CETA), most of these programs were combined into a single-block grant which transferred responsibility for administration to State and local governments.

The 95th Congress reauthorized this legislation as the Comprehensive Employment and Training Act Amendments of 1978 (Public Law 95-524). Section 2 of the act presented a statement of purpose as follows:

> It is the purpose of this act to provide job training and employment opportunities for economically disadvantaged, unemployed, or underemployed persons which will result in an increase in their earned income, and to assure that training and other services lead to maximum employment opportunities and enhance self-sufficiency by establishing a flexible, coordinated, and decentralized system of Federal, State and local programs. It is further the purpose of this act to provide for the maximum feasible coordination of plans, programs, and activities under this act with economic development, community development, and related activities such as vocational education, vocational rehabilitation, public assistance, self-employment, training, and social service programs.

Under the administrative provisions of this act, funds flow from the Secretary of Labor to "prime sponsors." A prime sponsor under this act may be a State; a unit of general purpose local government which has a population of 100,000 or more persons; any consortium of units of general purpose local government which include a qualifying unit of general purpose local government; and, any unit of general purpose local government or any consortium of such units, without regard to population, which may have exceptional circumstances as determined by the Secretary of Labor. Prime sponsors receive funds from the Secretary of Labor based on a comprehensive employment and training plan.

A. Older Workers Under CETA

The 1978 amendments, and subsequent regulations to implement these amendments, provided a greater focus on the employment problems of older workers. Title II, the new authority for employment and

training programs, provides that the Secretary of Labor shall insure that prime sponsors' plans contain procedures for services to be provided to individuals who are experiencing handicaps in obtaining employment, including those who are 55 years of age and older.

Under the provisions of the Older Workers Initiatives (title II, section 215), the DOL, through prime sponsors, was charged with implementing programs to develop work modes, making it possible for older workers to remain on the job, as well as providing retraining and other support activities.

Title III of the amendments provides broad authority for research and training policies and programs to focus on assuring older workers a more equitable share of employment and training resources to reflect their importance in the labor force. Section 308 of this title provides that the Secretary shall:

—Develop and establish employment and training policies and programs for middle-aged and older workers which will reflect the appropriate consideration of these workers' importance in the labor force and lead to a more equitable share of employment and training resources for middle-aged and older workers.

—Develop and establish programs to facilitate the transition of workers over 55 years of age from one occupation to another within the labor force.

—Conduct research on the relationships between age and employment and insure that the findings of such research are widely disseminated in order to assist employers in both the public and private sectors to better understand and utilize the capabilities of middle-aged and older workers; and

—Develop and establish programs to develop methods designed to assure increased labor force participation by older workers who are able and willing to work, but who have been unable to secure employment or who have been discouraged from seeking employment.

Title VII, Private Sector Opportunities for the Economically Disadvantaged, also requires employment and training opportunities for special groups such as middle-aged or older workers who have been unable to locate suitable employment. The title requires that such opportunities be available by prime sponsors on an equitable basis among segments of the eligible population. It further states that consideration must be given to the relative numbers of eligible persons in each such segment.

Despite the mandates of the CETA legislation, and the assertions by DOL that persons in all working age groups participate in activities under CETA, Congress has continued to express concern that the CETA program is not responsive to the needs of older workers. This concern was underscored in a 1978 study by Schram and Osten.[16] In this assessment of the impact of CETA on the problems of the older worker, the authors examined CETA's history, options and authority arriving at the following conclusions:

—Analysis of CETA data reveals that relatively few older people are served by the program, despite the long-term unemployment

[16] Aging and Work, vol. 1, No. 3, summer 1978.

suffered by the group. CETA criteria for distributing public jobs emphasize youth through special consideration of veterans, welfare recipients, and manpower trainees; and

—The authors find major systemic factors within the CETA program that encourage local prime sponsors to understate the needs of the aging population, concluding that there is a need for substantial changes in CETA if the older worker is to be served effectively.

An examination of participation figures provided by DOL for fiscal years 1979 and 1980 reveal that only a small percentage of prime sponsors provide special programs for older persons and that the percent of workers age 45 or older has declined under some titles. For example, under section 215, DOL reports that 89 prime sponsors provide special programs for approximately 12,000 older persons in 135 projects. The 89 prime sponsors which developed these special programs represent only 19 percent of the 473 fiscal year 1980 prime sponsors. Therefore, the data indicates that a substantial portion of the prime sponsors do not intend to operate programs designed for older workers. However, it should be noted, that some older workers are served by prime sponsors through regular CETA programs. Participation data from these programs are collected on an age "55-plus" category which almost precludes accurate determination of the numbers of older persons employed in regular CETA programs.

In the fiscal year 1982 budget materials published by DOL, the following tables provide socioeconomic characteristics of persons enrolled in CETA programs during fiscal year 1979 and fiscal year 1980. All tables show a decline in the number of participants in the 45 and over age bracket during this time frame.

COMPARISON OF ENROLLEE CHARACTERISTICS BETWEEN 1979 AND 1980 TITLE II-A, B, AND C

Characteristics	1979	1980
Sex:		
Male (percent)	47.1	47.0
Female (percent)	52.9	53.0
Age:		
Under 22	47.9	48.2
22 to 44	44.9	45.3
45 and over	7.2	6.5
Education:		
11 or less	47.5	49.1
12 and over	52.5	50.9
Economically disadvantaged	90.0	98.2

COMPARISON OF ENROLLEE CHARACTERISTICS BETWEEN 1979 AND 1980, TITLE II-D

[In percent]

	1979	1980
Economically disadvantaged	86	96
Female	48	50
21 or younger	23	26
45 or older	14	12
Handicapped	5	6
On public assistance	22	27
Less than high school education	28	33
Black	29	33
American Indian or Alaskan Native	1	2
Hispanic	13	13

COMPARISON OF ENROLLEE CHARACTERISTICS BETWEEN 1979 AND 1980, TITLE VI

[In percent]

	1979	1980
Economically disadvantaged	86	90
Female	43	45
21 or younger	22	24
45 or older	15	14
Handicapped	4	5

B. Reauthorization of Title VII

Title VII, first drafted as a provision of the 1978 CETA Amendments, established a private sector initiative program (PSIP) designed to encourage prime sponsors to work more closely with local private employers, organized labor, community-based organizations and educational agencies to experiment with approaches which would place disadvantaged persons in private sector employment.

On March 12, 1980, a bill to amend and extend title VII of CETA (H.R. 6796) was introduced by Congressman Hawkins. The House Committee on Education and Labor, to which the bill was referred, favorably reported the bill out of committee on May 15.

The House Committee on Education and Labor, in their report (H. Rept. 96–985) accompanying H.R. 6796; addressed problems that older workers encounter with CETA and charged DOL as follows:

> The committee reminds the Department of Labor of its obligations to insure that the CETA program better respond to the needs of older workers, whether it be in title VII or elsewhere.

The report also indicated both DOL and the prime sponsors regarding programs for older workers with the following statement:

> Despite the mandates of the 1978 CETA Amendments which called on prime sponsors to establish programs specifically for older workers, as of March 1980, only 89 of 473 prime sponsors had, in fact, established such programs. This represents less than 20 percent. The CETA program cannot continue to ignore the older worker. We instruct the prime sponsors to include older workers in any agreements they make with private industry under the terms of title VII.

The House passed H.R. 6796 on September 15, the Senate on December 8, and the measure was signed into law (Public Law 96–583) on December 23, 1980. With the passage of this legislation, Congress once again had affirmed support for employment and training programs for older workers.

Fiscal year 1980 appropriation provided $8.1 billion for CETA programs. DOL estimates that approximately $260.6 million, or approximately 3.2 percent, was spent on employment and training for workers age 55 and over as follows:

Title:	*Million*
II–B and C	$59.8
II–D	91.6
VI	99.2
III, section 308	2.1
III, migrants	5.2
III, Native Americans	2.8